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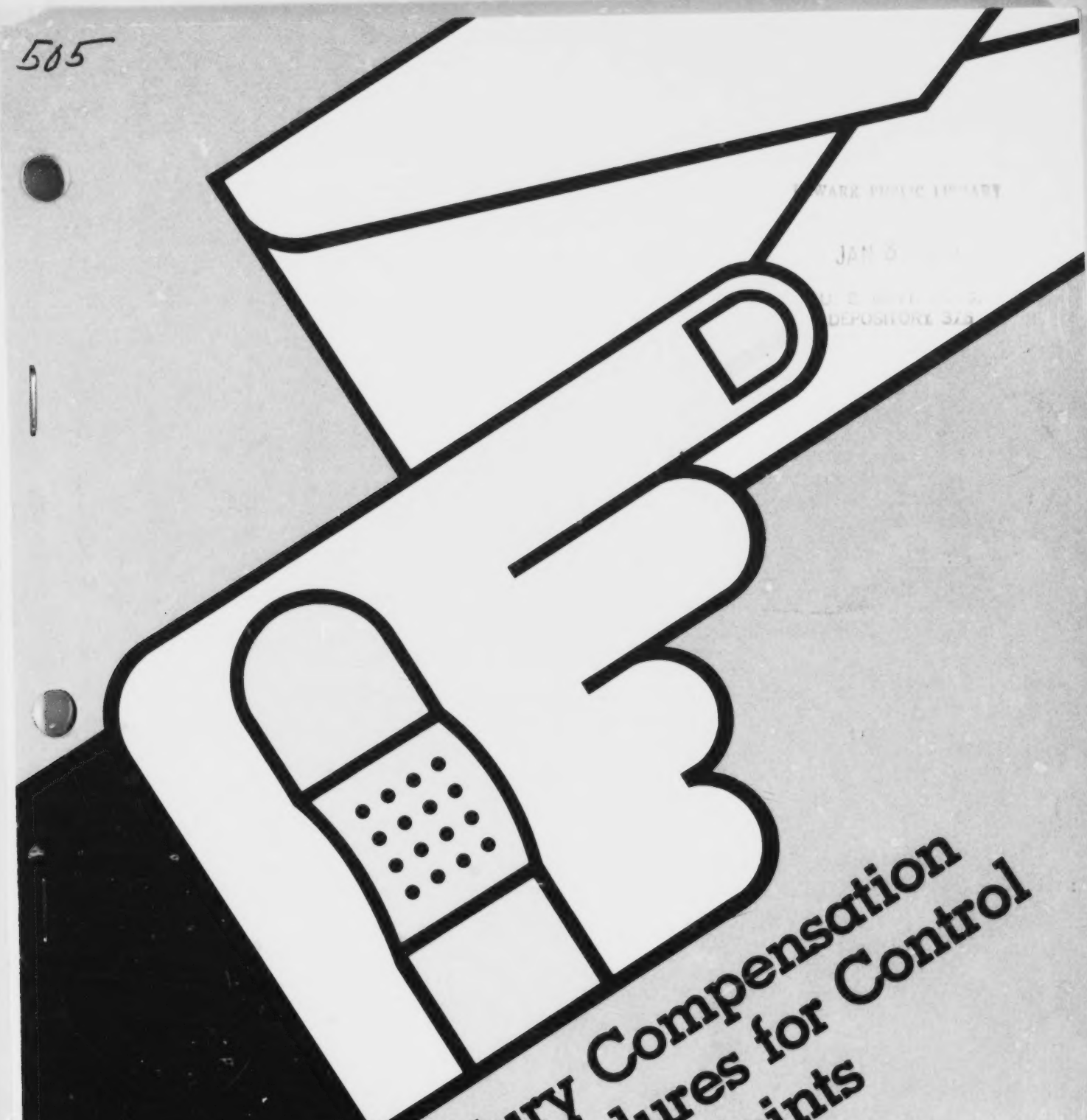


Injury Compensation Procedures for Control Offices/Points

HANDBOOK EL-505
OCTOBER 1985 (Revised)

READEX FICHE

P1.31/2:

U.S. POSTAL SERVICE
WASHINGTON, DC 20260

Handbook EL-505
INJURY COMPENSATION PROCEDURES

Issue 3
October 1985

A. MATERIAL TRANSMITTED

This is a complete revision of Handbook EL-505, with the exception of Chapter 5 on Rehabilitation, which is undergoing review by the Department of Labor. The handbook is for internal administrative purposes only and provides standard operating procedures to the field for the administration of elements of the Injury Compensation Program. It should not be cited as a source document for discipline procedure or any other action. Postal Service regulations concerning the Injury Compensation Program are contained in the Employee Relations Manual (ELM) subchapter 540, which can be cited, if necessary.

B. COMMENTS AND QUESTIONS

Comments and questions about the subject matter of this document should be addressed to:

Manager, Injury Compensation Branch
Office of Safety and Health
USPS Headquarters
Washington, DC 20260-4230
Phone #: FTS 245-4678

C. DISTRIBUTION

Copies of the handbook will be available at the area supply centers. Use Form 7380, Supply Center Requisition when ordering.

D. OTHER INSTRUCTIONS

Destroy all copies of the February 1984 issuance of the handbook and replace it with revised version.

David H. Charters
Assistant Postmaster General
Employee Relations Department

CONTENTS

Chapter 1--General Information

110 Purpose and Scope

120 Background
121 Department of Labor (DOL) Involvement
122 USPS Involvement

130 General Provisions of the FECA

140 Responsibility
141 OWCP
142 USPS
142.1 National Headquarters
142.2 Regional Headquarters
142.3 District Office - District Manager
142.4 Management Sectional Center and Bulk Mail Center

150 Definitions/Abbreviations
151 Definitions
152 Abbreviations

160 Setting Objectives
161 Introduction
162 Budget
163 COP Control
164 Staffing
165 Training
166 Rehabilitation
167 Third Party
168 Interface Relationships

Chapter 2--Claims Management

210 Elements of the Injury
211 Introduction
212 Occurrence of Injury
213 Filing the Claim
214 Authorizing Medical Examination and/or Treatment
215 Status Determination
216 Limited/Full Duty
217 COP, AL/SL, LWOP
218 Emergencies

220 Elements of the Claim
221 Responsibilities of the Control Office
221.1 Notification of Injury to Control Office
221.2 Registers and Folder Preparation
221.3 Claim Investigation
221.4 Claims Package
221.5 Assignment of OWCP Claim Number
221.6 Controversion of Traumatic Injury or Nonconcurrence of Occupational Disease/Illness or Recurrence (See Chapter 7).
221.7 To Avoid Interruption of Pay When COP Ends
221.8 Third Party Liability (See Chapter 8)

Chapter 3--Records Management

310 General

320 Files and Form Preparation
321 Files
322 Form Preparation
322.1 Prepare the following forms timely and accurately.
322.2 Form CA-1, Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (Rev. 10/83).

322.3 Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation (Rev. 4/85).

322.4 Form CA-2a, Notice of Employees' Recurrence of Disability and Claim for Pay/Compensation (Rev. 2/84).

322.5 Form CA-3, Report of Termination of Disability and/or Payment.

322.6 Form CA-4, Claim for Compensation on Account of Occupational Disease (Rev. 9/84), with attached Form CA-20, Attending Physician's Report (Rev. 9/84).

323 Additional Claim Forms

323.1 Form CA-5, Claim for Compensation by Widow, Widower and/or Children.

323.2 Form CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.

323.3 Form CA-6, Official Superior's Report of Employee's Death.

323.4 Form CA-7, Claim for Compensation on Account of Traumatic Injury (Rev. 6/84), with attached Form CA-20, Attending Physician's Report.

323.5 CA-8, Claim for Continuation Compensation on Account of Disability (Rev. 4/84), with attached Form CA-20a, Attending Physician's Supplemental Report (Rev. 4/84).

323.6 Form CA-16, Request for Examination and/or Treatment (Rev. 6/84).

323.7 Form CA-17, Duty Status Report (Rev. 7/84).

330 Registers, Logs, and Reports

331 Purpose

332 Time Requirements

333 Master Claim Log

334 Claim Control Register

335 Controversion Log

336 Third Party Register

337 Rehabilitation Log

338 Reports

338.1 Purpose

338.2 Form 2572, Injury Compensation Data Collection (Rev. 6/84)(See Exhibit 3-21)

338.3 Chargeback Report.

338.4 Workers' Compensation Injury on Duty Report.

338.5 Rehabilitation Tracking Report.

338.6 OWCP Potential Rehabilitation Candidate Status Report (RCSR).

350 Form 2573, Inquiry on Claim Status.

360 Injury Compensation Records Access and Disclosure Guidelines

361 Types
362 Injury Compensation Case Files
363 Injury Compensation Claim Status Records
364 Injury Compensation Program Administrative and General Office Records
365 Responsibility
365.1 Installation Head
365.2 Injury Compensation Control Personnel
366 Access and Disclosure Guidelines
366.1 Protection of Records
366.2 Employee's Access to Own Records

Chapter 4--Timekeeping and Accounting Procedures

410 Purpose

420 Compensation Procedures
421 Input and recovery of continuation of pay.
421.1 Definition
421.2 Use of COP
421.3 COP Limitation
422 COP Applicability
423 Authorization and Supporting Forms
424 Special Instructions
424.1 Minimum COP Benefits
424.2 Premium Benefits
424.3 Holidays Within COP
424.4 "Proximity Rule" - Rural Carriers
424.5 Election Changed within 45 Day Period
425 First Aid Examination and Treatment for On-the-Job Injury or Illnesses
425.1 Employee on Regular Tour
425.2 Employee in Overtime Status
427 COP Entries-EAS Employees
428 Continuation of Pay Beyond Separation
428.1 General
428.2 Identification of Separated Employee in COP Status
429 COP for Disability "Beginning After" Separation

430 Other Compensation Issues
431 Recurrence
432 Pay Adjustments and Recovery
432.1 Overpayment-Erroneous Timekeeping Entries
432.2 Overpayment Determination
433 Eligibility for LWOP/IOD-OWCP
434 Labor Distribution Code
434.1 Code/Operation Numbers
434.2 Limited Duty
435 Leave Buy-Back
436 Internal Revenue Service (IRS) Ruling Relating to "Buy-Back" Leave

440 Limited Duty Assignments

450 Health Benefits Refund Program

Chapter 5--Rehabilitation

(Will be published at a later date)

Chapter 6--Fraud and Abuse

610 Purpose

620 Objectives of Fraud and Abuse Program

630 Definitions

640 Types of Fraud and Abuse

650 Warning Signals for Fraud and Abuse Cases

660 Identification

670 Actions Required for Inspection Service Referrals

Chapter 7--Controversions

710 Purpose

720 The Controversion Package
721 General
722 Cover Letter
723 Exhibits

730 Types of Controversions
731 Controversion of the Entire Claim
732 Partial Controversion
733 Controversion with Termination of COP
734 Controversion without Termination of COP
735 Nonconcurrence of Occupational or Recurrence Claims

740 Requirements for Adjudication by the OWCP

Chapter 8--Third Party

810 Purpose

820 Background

830 Responsibility

840 Procedures
841 Identification of Potential Third Party Claim
842 Investigation
843 Notice
844 Course of Action
845 Settlement of Claims
846 Disbursement of Recovered Third Party Funds
847 Third Party Case File

850 Control Point Supervisor, Additional Requirement

860 Recovery Assistance
861 Control Officer
862 RICPA
863 Office of the Regional Counsel
864 Claims Division, Law Department, Headquarters

870 Delegation of Authority

880 Negotiating Third Party Settlements
881 Purpose
882 Definitions of Terms as used in the Injury Compensation Program
883 Negotiation Strategy

Chapter 9--Miscellaneous

910	**Program Reviews**
911	Purpose
912	Objectives of Program Reviews
913	These objectives will be met by:
914	Program Responsibility
915	Review Frequency
916	Reporting
917	Areas of Concern
918	Other Review Concerns
920	**Providing Counsel and Assistance**
921	General Information
922	Information for Supervisors:
930	**Guidelines for OWCP Hearings**
931	Right to Hearing
932	Notice of Hearing
933	Subpoenas
934	Role and Responsibility of the Injury Compensation Supervisor/ Specialist
935	Transcript of Hearing
940	**Directory of OWCP District Offices**

Chapter 1
General Information

110 Purpose and Scope

The purpose of this handbook is to provide guidance to the Injury Compensation Supervisor/Specialist and Control Point Supervisor in administering the USPS Injury Compensation Program in accordance with the Federal Employees' Compensation Act (FECA).

120 Background

121 Department of Labor (DOL) Involvement

In 1908, President Theodore Roosevelt signed legislation to provide workers' compensation for certain Federal employees in usually hazardous jobs. The scope of the law was very restricted and its benefits were quite limited. However, it was the first workers' compensation law to pass the constitutionality test of the U.S. Supreme Court. The Federal Employees' Compensation Act (FECA), enacted in 1916, superseded the 1908 statute. The FECA is a workers' compensation law for all civilian Federal employees. It includes wage loss compensation, medical care, and survivors' benefits provisions. An independent quasi-judicial Employees' Compensation Commission was created to administer the law. Administrative responsibility for the FECA was assigned to the Department of Labor in 1950. The Act is now administered by the Office of Workers' Compensation Programs (OWCP), Employment Standards Administration, U.S. Department of Labor. In 1974 the FECA was amended, increasing benefits and significantly changing the law by adding provisions such as continuation of pay and claimant's choice of physician. The effect of this amendment eventually led to the establishment of the USPS Injury Compensation Program (ICP).

122 USPS Involvement

As the cost of workers' compensation benefits escalated, the need for a comprehensive control program within the USPS became necessary. Although the administration of the FECA is the responsibility of the Department of Labor, Office of Workers' Compensation Programs (OWCP), the cost of benefits is borne by the employing agency. In 1978 the USPS initiated the ICP to deal with these escalating costs by staffing designated control offices throughout the

country with trained personnel to administer USPS responsibilities under the Act.

130 General Provisions of the FECA

a. Compensation and Other Allowances. Essentially, the Federal Employees' Compensation Act provides medical care, rehabilitation, attendant's allowance, and monetary compensation to employees of the Federal government who are disabled as a result of their employment. In the event of death due to employment, the Act provides up to $800 for funeral and burial expenses and $200 for the administrative costs of terminating a decedent's employee status with the Federal government. In addition, monetary compensation and educational benefits are paid to certain survivors of a decedent whose death is due to employment.

b. Continuation of Pay (COP). An employee who sustains a disabling job-related traumatic injury is entitled to continuation of regular pay for a period not to exceed 45 calendar days of disability. Under normal circumstances, in order to qualify for continuation of pay, the traumatically injured employee must file written notice of injury on a CA-1 and claim for continuation of pay within 30 days of the date of injury. Continuation of pay is not defined as an injury compensation benefit for FECA purposes and is subject to all applicable taxes and other payroll deductions. The employee must make separate claim for monetary compensation on a CA-7 if the disability exceeds 45 days or results in any permanent disability.

c. Filing Requirement for Eligibility. In order to qualify for compensation benefits (both traumatic and nontraumatic), an injured Federal employee must file a notice of injury and claim compensation within three years from the date of injury/illness. In the case of death, the survivors must file claim within the same period of time. However, if the decedent had timely filed a disability claim for an on-the-job injury, that filing satisfies the time requirements for a death claim based on the same injury. It must also be shown that the injury or death was causally related to the employment. The term injury includes any disorder proximately caused by the employment. Aggravation of a pre-existing condition by employment is also compensable. The term injury also includes damage or destruction of medical braces, artificial limbs and other prosthetic appliances; and monetary compensation is

allowable for periods of disability caused by the necessity for replacement or repair of such items. Eyeglasses and hearing aids may be repaired or replaced only if the damage is due to an injury that requires medical treatment.

d. Medical Care. If an injury is accepted as compensable under FECA, the injured employee is entitled to all medical care that is required to cure, give relief, or reduce the degree or period of disability. There is no dollar maximum or time limitation on medical care. It will be provided as long as the evidence indicates it is needed for the effects of the job-related injury.

e. Rehabilitation. If the injured party suffers a vocational handicap due to the injury and cannot resume usual employment, rehabilitation services may be arranged to assist in training for work that the claimant can perform. Rehabilitation service is supervised by the OWCP, but is usually provided in cooperation with state rehabilitation agencies. When rehabilitation is under way, the OWCP may provide a monthly maintenance allowance not to exceed $200 in addition to compensation for wage loss.

f. Attendant Allowances. Employees who are injured so severely that they are unable to provide their own physical needs such as feeding, bathing, or dressing, may qualify to receive an attendant's allowance up to a maximum of $500 per month. This allowance may be paid in addition to compensation for wage loss.

g. Compensation Rates. Generally, in cases of total disability an employee is entitled to compensation equivalent to two-thirds of the weekly salary if there are no dependents, or three-fourths of the salary if there is one or more dependents. In establishing a person's wage rate, the law recognizes certain additional amounts that may be included in salary, such as premium pay, night and Sunday differential, and cost of living allowance.

h. Duration of Compensation. Compensation payments for total disability may continue as long as the disability continues. As with medical care, there is no total dollar maximum or time limitation. Compensation for total disability may continue for the lifetime of the employee.

i. Loss of Wage-Earning Capacity (LWEC). When an injured person suffers a wage loss because of a disability that is less than total, compensation may

be paid for loss of wages or wage earning capacity. Provisions of 5 USC 8115 govern the determination of wage-earning capacity. The injury compensation supervisor/specialist may request that a LWEC determination be made by the OWCP claims examiner if sufficient medical evidence indicates that an individual who is receiving compensation has attained maximum medical improvement and has not returned to work.

j. Schedule Awards. The FECA also provides for payment of compensation for permanent loss or loss of use (either partial or total) of certain internal organs, members, or functions of the body such as arms, legs, hands, feet, fingers, toes, eyes, and loss of hearing or loss of vision. Each extremity or function has been rated for a specific number of weeks of compensation which can be paid even though the employee returns to work at full salary. If a serious disfigurement of the head, face, or neck results from a job-related injury, an award may also be made for such disfigurement, not to exceed $3,500. Multiple schedule awards may be paid concurrently for different body parts and may also be paid concurrently with OPM retirement benefits. However, employees cannot receive wage loss compensation and schedule award benefits concurrently for the same injury.

k. Survivor Benefits.

1. **Surviving Widow or Widower, No Surviving Eligible Children.**

The widow or widower receives 50% of the deceased employee's salary.

2. **Surviving Widow or Widower and One or more Surviving Eligible Children.**

a. The widow or widower receives 45% of the deceased employee's salary.

b. One child receives 15%. Two or more children receive 30% shared equally.

3. **Widow or Widower, One or More Surviving Children.**

a. One child receives 40% of the deceased employee's salary.

b. Two or more children receive 40% for the first child plus 15 % for each additional child, up to a maximum of 75%-- shared equally among all the children.

Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate or 75% of the top step of a GS-15 of the General Schedule in the Classification Act of 1949, whichever is less. Other persons who may also qualify for benefits are dependent parents, brothers, sisters, grandparents, and grandchildren; however, the surviving widow, or widower, and children have first priority.

l. Adjustments. In general, if compensation has been paid in either a disability or death case for more than a year, or the pay rate upon which compensation is based is more than one year old, adjustments based on the Consumer Price Index are made. Such increases become a part of long term disability benefits.

m. Third Party Liability. An employee who sustains a job-related injury cannot recover damages from the United States for the effects of injury except through the FECA. An employee who refuses to pursue recovery from a liable third party after being asked to do so by the Department of Labor may be denied compensation. In instances in which an employee's injury or death in the performance of duty occurs under circumstances creating a legal liability on some person other than the United States government, the USPS may assist in obtaining a settlement. Any settlement monies are to be distributed in the following manner:

1. Expenditures by the USPS and benefits paid by the OWCP are refunded, minus a percentage equal to the attorney's contingency fee percentage.

2. In any event, the employee retains at least one-fifth of the settlement (excluding attorney fees and costs), even if this results in the USPS and the OWCP not receiving part or all of the amounts provided for in #1 above.

3. The USPS and the OWCP receive monies only as provided for in #1 above. Any monies remaining after both 1 & 2 above are satisfied (the surplus) are retained by the employee.

n. Review of OWCP Decisions. If an employee or the survivors disagree with the final determination made by OWCP, a hearing may be requested to give the claimant an opportunity to present evidence in further support of the claim. Also, there is a provision for additional review by the OWCP and a right to appeal to

the Employees' Compensation Appeals Board, a separate entity of the U. S. Department of Labor.

o. Filing Instructions. Employees who sustain injuries or occupational diseases related to Federal employment, should contact their supervisors for the forms used to file a report of injury and claim for compensation. Further assistance may be obtained through the local injury compensation control office/point.

p. More Detailed Information on the coverage and provisions of the FECA is available from OWCP. This information may be obtained by writing to the local OWCP district office as listed in section 940.

140 Responsibility

141 OWCP

The principal responsibility of the Office of Workers' Compensation Programs (OWCP) is to adjudicate workers' compensation claims. Claim decisions, determinations, and adjudications are made in the name of, or for, the Director, OWCP. This function is quasi-judicial in character and involves the application of statutes and principles of law to resolve factual situations. This field of activity is within the specialized branch of law generally referred to as "workers' compensation." OWCP promulgates the rules, regulations, and policies under which Federal employee compensation benefits are applied.

142 USPS

142.1 National Headquarters

The Manager, Injury Compensation Branch:

a. Establishes policy and procedures through the Senior Assistant Postmaster General (SAPMG), Employee & Labor Relations Group; coordinates and provides technical assistance in field activities to ensure uniform management of the program.

b. Identifies needs for training those involved in administering the program.

c. Coordinates efforts with the Department of Labor in conjunction with the Postal Service's responsibilities under the FECA.

d. Provides reports relevant to the status of the program.

e. Sets national goals and objectives in relation to effective control of the program.

142.2 **Regional Headquarters**

.21 Regional Postmaster General (RPMG): Implements Headquarters Injury Compensation Program policies and directives.

.22 Regional Director of Employee and Labor Relations: Oversees regionwide ICP activities within the policies and guidelines of the program.

.23 Regional Injury Compensation Program Administrator (RICPA)

a. Advises Headquarters on the status of the Injury Compensation Program within the region and assists in the administration of policy, programs, and procedures that affect the program.

b. Provides technical assistance and guidance to District, Management Sectional Center (MSC), and Bulk Mail Center (BMC) Managers and their assigned control office personnel in relation to the program.

c. Sets regional goals and objectives within the guidelines established by Headquarters.

142.3 **District Office - District Manager**

Implements Headquarters program policies within regional objectives and action plans throughout the district.

142.4 **Management Sectional Center and Bulk Mail Center**

.41 MSC/BMC Managers implement the objectives and policies of the program in the facilities under their jurisdiction.

.42 Control Office. In MSCs and BMCs authorized injury compensation staffing, the injury compensation staff administers the Injury Compensation Program and coordinates the efforts of all control point supervisors under the jurisdiction of the MSC/BMC. In some cases, the control office may be administratively responsible for more than one MSC/BMC. (See Subchapter 150 for complete definition).

.43 Control Point Supervisor

The supervisor who is designated by the installation head to authorize medical treatment and coordinate the activities of first-line supervisors for reporting injuries at the facility. (See Subchapter 150 for complete definition).

150 Definitions/Abbreviations

151 Definitions

For the purposes of the Injury Compensation Program, except where the contents clearly indicate otherwise, the following definitions apply:

Chargeback - The system of billing Postal Service Headquarters for payments related to OWCP-approved claims and then having them charged to the local USPS installation having jurisdiction over the employee at the time of the injury/illness.

Claim Control Register - An individual claim log that provides the basic data related to each claim in a brief chronological format. It is located on the left side of the employee's file folder.

Claimant - An individual whose claim for entitlement to benefits under the Act has been filed in accordance with the provisions of the Act.

Claims Examiner -- An employee of OWCP possessing special training and experience in claims adjudication.

Compensation - Benefits or compensation paid or payable under the Act, including money paid because of loss of wages, medical expenses, rehabilitation expenses, and loss of use of major body functions; and death benefits to the survivor(s).

Continuation of Pay (COP) - A traumatically injured employee may request continuation of his regular pay with no charge to sick leave or annual leave for the first 45 calendar days of disability. COP is subject to taxes and all other usual payroll deductions.

Control Office (CO) - Staff of employees at selected MSCs and BMCs who administer and control all aspects of the Injury Compensation Program. The staff reports administratively and functionally to the Injury Compensation Supervisor (ICS). At smaller installations the control office may be the medical,

health or safety unit. In the absence of an ICS, a control officer designated by the installation head and functioning in a collateral duty capacity will administer injury compensation matters.

Control Point (CP) - The CP is an office or individual (for example, station manager, tour supervisor, etc.) in installations that do not have a control office (for example, an associate office, an SCF with no control office, etc.) authorized by the installation head to issue the Form CA-16, *Request for Examination and/or Treatment*, and to clear personnel for duty.

Controversion - The formal administrative procedure through which USPS management presents evidence to OWCP to challenge an employee's claim for benefits. Management may controvert claims for COP that are clearly in conflict with the provisions of the regulations, or if there is serious doubt as to the validity of the claim. Termination of COP can be accomplished for any of the nine reasons listed on Form CA-1. Controversions must be thoroughly documented and submitted at the earliest date the facts are available.

Employee Assistance Program (EAP) - Subchapter 870 in the ELM, previously entitled Program for Alcoholic Recovery (PAR), has been revised and expanded into an Employee Assistance Program. PAR focused on assisting employees to recover from alcoholism. However, EAP has been established primarily to assist postal employees in their efforts to recover from alcohol and drug abuse, thereby eliminating the harmful effects these conditions may have on the individual's employment.

An employee may be referred to EAP if there is strong suspicion/evidence that alcohol or drug abuse has directly or indirectly caused an injury. Management can require the employee to attend the initial EAP interview; however, an employee's participation in this program is voluntary.

Employee & Labor Relations Manual (ELM) - Subchapter 540 is the primary reference for policies and procedures governing the USPS ICP.

Federal Employees' Compensation Act (FECA) - Outlines the statutory regulations for the workers' compensation program which is identified in 5 USC 8101 sequence, as amended in 1974.

Fitness-for-Duty Examination (FFD Exam) - A physical exam by the USPS medical officer or contract equivalent to determine the employee's current medical status. The results are documented on Form 2485, *Medical Examination and Assessment,* which becomes part of the OWCP case file. A copy should be retained in the employee's official medical folder in the medical facility. The purposes of the FFD exams are to:

(1) Evaluate medical status.

(2) Confirm/verify limited duty assignments.

(3) Assist in the rehabilitation effort.

(4) Support a controversion.

A fitness-for-duty examination is conducted in cases of traumatic and occupational illness or disease when necessary to confirm the extent and/or job-relatedness of the claim filed.

Health Unit - A unit in a postal facility staffed with one or more nurses who provide medical services to personnel who work within that facility.

Injury Compensation Supervisor/Specialist (ICS) - The person who is responsible for organizing, managing, and coordinating the Injury Compensation Program within a designated area, usually a management sectional center. This person provides technical guidance to supervisors and employees within the assigned area concerning USPS policies and procedures related to injury compensation; assures proper implementation of the program; and supervises assigned injury compensation staff members.

Joint USPS/DOL Rehabilitation Program - Original guidelines developed by the Department of Labor and USPS in October 1979 to return both former and current employees with job-related disabilities to productive work as early as possible.

Labor Distribution Code (LDC) - A code number that identifies the major work assignment of the employee.

The LDCs pertaining to the injury compensation area are:

68 Limited Duty - Workhours of all employees who are temporarily assigned to a modified position, either

part or full-time, in order to accommodate medical restrictions imposed as a result of a job-related injury/illness. This does not include employees who are performing their regularly assigned duties with minor modifications.

69 Rehabilitation - Workhours of all former employees rehired or current employees permanently reassigned to a modified assignment under provision of the Joint USPS/DOL Rehabilitation Program because of a documented permanent partial disability. The procedure for using LDC 69 requires that 69 be entered under item 64 of Form 50, *Request for Personnel Action*. Removal from the Rehabilitation Program also requires a Form 50 action.

Light Duty - The assignment (temporary or permanent) of an employee partially disabled from an off-the-job injury or illness. The employee must submit a written request to the installation head, accompanied by a medical statement from a licensed physician, indicating the anticipated duration of the convalescence period. Light duty assignments are subject to the "Light Duty" provisions of the applicable collective bargaining agreements.

Limited Duty - The temporary or permanent assignment to productive duty of an employee who is partially disabled from a job-related injury or illness and is unable to perform his regular duties. The employee's return to work must be recommended by appropriate medical authority and the tasks assigned must be fully consistent with the physical limitations specified by such medical authority.

Medical Unit - A unit in a postal facility staffed with a medical officer(s) and nurse(s) who provide medical services within that facility and other offices in the assigned geographic area.

Occupational Disease or Illness - An illness or disease produced by: systemic infections; continued or repeated stress or strain; exposure to toxins, poisons, fumes, etc.; or other continued and repeated exposure to the work environment over a period greater than a single day or work shift. For example, an asthmatic condition caused by breathing contaminated air would be an occupational disease. Persons suffering from occupational diseases are limited to injury compensation payments provided by the FECA or to sick or annual leave. Continuation of pay is not authorized

for occupational disease or illness. No medical payments are provided until the claim is adjudicated and approved by OWCP. The CA-16 cannot be authorized unless prior approval is given by OWCP.

Office of Workers' Compensation Programs (OWCP) - The Office of the Department of Labor (DOL) that has overall responsibility for the administration of FECA.

Periodic Roll - A system utilized by OWCP whereby the U. S. Treasury pays prolonged disability cases each 28 days and death cases each month automatically until advised otherwise by OWCP.

Recurrence - The reappearance of the original symptoms/pains of a previously reported and accepted injury. The recurrence must not have been caused by a specific act or a series of acts.

Third-Party Liability - Those instances in which an injury or illness suffered by a Postal Service employee is caused by a person not under the employ of the Postal Service or any branch of the federal government.

Traumatic Injury - A wound or other condition of the body caused by external force, including stress or strain. It must be identifiable as to time and place of occurrence and member or function of the body affected. It must be caused by a specific event or incident, or series of events or incidents within a single day or work shift. For example, a strained back caused by lifting a mail sack would be a traumatic injury. Only traumatic injuries entitle employees to COP. Traumatic injuries include damage to or destruction of prosthetic devices or appliances. Eyeglasses and hearing aids are excepted, unless damaged or destroyed as a direct result of a job-related personal injury requiring medical services.

152 **Abbreviations**

CE	Claims Examiner
CO	Control Office
COP	Continuation of Pay
CP	Control Point
DOI	Date of Injury

DOL	Department of Labor
ECAB	Employee Compensation Appeals Board
ELM	Employee and Labor Relations Manual
FECA	Federal Employees' Compensation Act
FFD	Fitness-for-duty
ICS	Injury Compensation Supervisor/Specialist
ICO	Injury Compensation Office
ICP	Injury Compensation Program
IRIS	Information Retrieval and Inquiry System
IS	Inspection Service
LD	Limited Duty
LDC	Labor Distribution Code
LWOP	Leave Without Pay
MSPB	Merit Systems Protection Board
OPM	Office of Personnel Management
OWCP	Office of Workers' Compensation Programs
RCSR	Rehabilitation Candidates Status Report
RICPA	Regional Injury Compensation Program Administrator
RS	Rehabilitation Specialist

160 Setting Objectives

161 Introduction

To achieve a well-managed Injury Compensation Program, certain objectives must be established and met. The program objectives are presented here for local implementation in an effort to control and reduce USPS workers' compensation expenses. For each objective mentioned, an action plan will be provided.

162 Budget

162.1 Objective: To reduce total compensation costs billed to the U.S. Postal Service by a specified percentage based on past achievement rate.

162.2 Action Plan: Provide suitable limited duty work to individuals on compensation rolls who are determined by competent medical authority to be able to perform such duties. USPS must make a concerted effort to identify as many limited duty positions as possible for placement of those individuals who are capable of performing in such positions. Implementation of this program will significantly reduce compensation costs.

163 COP Control

163.1 Objective: To control the use of COP.

163.2 Action Plan: Effort must be placed on "managing" injury claims rather than just "processing" them. Fitness-for-duty exams and limited duty assignments will reduce COP costs and LWOP/IOD use. Controlling COP use will minimize the number of new cases added to OWCP payment rolls.

164 Staffing

164.1 Objectives: To staff those installations that are not staffed with an adequate injury compensation complement.

164.2 Action Plan: Analyze workload carefully and prepare justification for staffing requests to show how the return on your investment can be realized.

165 Training

165.1 Objectives: To provide comprehensive training for full-time newly-appointed and collateral duty injury compensation personnel.

165.2 **Action Plan:**

.21 Formal training. Each district office should nominate their injury compensation personnel to attend the Injury Compensation Program Administration course offered at the William F. Bolger Management Academy, Potomac, Maryland. Training nominations must be submitted on Form 1782, Training Request, Authorization, and Record, to the registrar's office in Potomac at

least eight weeks before the beginning of the course. Scheduled dates can be obtained from the RICPAs.

.22 **Other Training**

To keep abreast of policy and procedural changes, each region should conduct short training sessions, where appropriate, to emphasize important aspects of the program to injury compensation personnel.

.23 **PEDC Training**

A self-study course, *The Injury Compensation Program: The Supervisor's Role and Responsibilities* is available at all Postal Employee Development Centers (PEDCs). Supervisors should take the course as soon as practicable. Since this is an ongoing course, any newly-appointed supervisors will be required to take it. Procedures are outlined in Management Instruction, EL 540-81-5.

166 Rehabilitation

166.1 Objective: To return all employees (both former and current) injured on duty to productive employment consistent with their medical limitations.

166.2 **Action Plan:**

a. Monitor the number and quality of official referrals made by the OWCP.

b. Provide timely reemployment offers to these individuals and follow-up on responses made.

c. Monitor chargeback report for candidates to identify to the OWCP for official referral.

167 Third Party

167.1 Objective: To aggressively pursue maximum recovery of all government funds due as a result of third party liability.

167.2 **Action Plan:**

a. Identify all third party claims and utilize the third party procedures in ELM 545.8.

b. Monitor claim form (CA-1) closely for proper endorsement of block 37.

168 Interface Relationships

168.1 Objective: To establish better working relationships and communications with other offices in order to achieve maximum support and cooperation towards reducing USPS compensation costs.

168.2 **Action Plan:**

a. Seek professional expertise from EAP, medical, and safety personnel on matters of mutual concern.

b. Keep communication channels open with management at all functional levels concerning specific activities of the Injury Compensation Program. (i.e., rehabilitation, third party recovery, limited duty, etc.)

c. Establish effective report and communication line with District OWCP offices.

Chapter 2
Claims Management

210 Elements of the Injury

211 Introduction

This is one of the most important chapters in the book. It provides step-by-step procedures for handling a claim once an injury/illness is reported. How an injury/occupational illness claim is handled at the beginning can directly affect the benefits received prior to its adjudication. Injury Compensation personnel must properly monitor claims to ensure that claimants' rights are protected, that appropriate management options are exercised in a timely manner, and that workers' compensation costs are effectively controlled.

212 Occurrence of Injury

Upon notification that an injury, occupational illness, or recurrence of a documented injury has occurred, the employee's immediate supervisor must take time to listen and discuss with the employee the nature of the injury, how it took place, when it took place, where it took place and obtain the names of any witnesses, if appropriate. Once these facts are obtained and the "type" of injury is identified, the supervisor will provide and/or prepare the appropriate form(s) for submission.

213 Filing the Claim

213.1 After the type of injury has been identified, the employee and supervisor must prepare the appropriate form(s) as indicated below:

a. CA-1, *Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay and Compensation.* This form is for traumatic injury cases only. (See Subchapter 150 for definition of traumatic injury).

b. CA-2, *Federal Employees' Notice of Occupational Disease and Claim for Compensation.* (See Subchapter 150 for definition of occupational disease).

c. CA-2a, *Notice of Employees' Recurrence of Disability and Claim for Pay and Compensation.* Note: Claimant is to be referred to the control office/point

for proper filing of a recurrence claim. However, the employee's supervisor or control office/point will prepare Part A of the CA-2a based on information supplied by the claimant. In the event the claimant is incapacitated, the claim may be made by telephone to the control office/point and annotated as such in item 19 of the form.

213.2 Completeness and Accuracy

The supervisor will insure the completeness and accuracy of each claim prepared prior to submission to control office.

213.3 Emergency Cases

In emergency cases it is not necessary to take time to fill out the necessary forms; however, these forms must be submitted within the time frame outlined in Chapter 3.

214 Authorizing Medical Examination and/or Treatment

214.1 If the employee needs and/or requests medical care, the supervisor or control office/point will:

a. Advise employee that he has a choice of physician.

b. Prepare and issue Form CA-17, *Duty Status Report.*

c. Refer employee to control office/point for issuance of CA-16, *Request for Examination and/or Treatment* and HCFA-1500, *Health Insurance Claim Form,* with OWCP-1500a, instructions attached.

214.2 The control office/point will:

a. Make an appointment with physician of employee's choice.

b. If physician is not available, inform employee that he must make another choice.

c. Issue CA-16 and HCFA-1500 to physician providing treatment and inform employee that a change of physicians is not authorized without prior OWCP approval.

d. Instruct employee to contact control office/point immediately after examination and/or treatment.

e. Inform employee that it is the employee's responsibility to provide medical evidence as to his duty status and that he must advise the physician of the fact that limited duty is available should the employee be physically able to perform such duty.

214.3 The employee must:

a. Advise control office/point of choice of physician.

b. If initial choice is not available to give examination, employee must choose one who will be able to give timely examination/treatment..

c. Inform physician of the availability of limited duty.

d. Notify the control office/point of Duty Status, as indicated on CA-17 by physician, immediately following treatment.

215 **Status Determination**

215.1 If the employee is medically able to do so, the CA-17 and/or other medical evidence must be returned immediately after examination or at the start of the employee's next scheduled work shift to his supervisor or control office/point so that employee's status can be determined.

215.2 Upon determination of status, the employee will either be:

a. returned to full duty

b. assigned to limited duty

c. placed in a COP status

d. placed in a S/L, A/L, LWOP status

216 **Limited/Full Duty**

216.1 If the employee is found fit for full duty, he must return to his regular assignment.

216.2 If the employee is found fit for limited duty, a limited duty assignment within the employee's physical limitations must be made available.

217 COP, AL/SL, LWOP

217.1 The employee will be placed in a COP status beginning the next full day or work shift if:

a. According to the employee's physician the employee is not fit for duty; and

b. COP is selected on the CA-1; and

c. The claim is not controverted under any of the circumstances listed in item 6 of the instructions for completing Form CA-1.

The duration of COP should be monitored closely. Dates of eligibility for COP should be compared with medical reports regarding employee's inability to work.

217.2 In cases where the employee has elected SL/AL and in all occupational illness cases, the employee will be placed in a leave status. LWOP will not be used until S/L has been exhausted.

218 Emergencies

In emergency situations the employee will be sent to the nearest available physician or hospital. When appropriate, a supervisor will accompany the employee to the doctor's office or hospital to make certain that the employee receives prompt medical treatment. Animal bites or eye injuries are generally considered medical emergencies. The physician who provides the emergency treatment is not usually considered the employee's initial choice of physician unless the employee elects to obtain follow-up care from the same physician. Supervisors should not accompany employees to the doctor's office in non-emergency cases.

220 Elements of the Claim

221 Responsibilities of the Control Office

The management of the claim from submission to adjudication by the U.S. Department of Labor is the responsibility of the control office. All claims and allied correspondence from the control points must flow through the control office before being forwarded to the OWCP.

221.1 Notification of Injury to Control Office

The supervisor will notify the control office/point supervisor immediately or as soon as possible after an injury has been reported. This is most important so that the control office/point can get involved and administer the claim from the onset.

221.2 Registers and Folder Preparation

Upon receipt of the CA-1, CA-2 or CA-2a, the Control Office/ Point will:

a. Prepare a case folder (See Chapter 3). Note: CA-2a will be filed with original claim.

b. Enter in Master Claim Log and Claim Control Register.

c. Log in other appropriate registers (controversion, third party etc.) as indicated in the Records Management Chapter. (See Chapter 3).

221.3 Claim Investigation

Investigation of the claim by the immediate supervisor should start immediately upon notification that an injury has occurred. The control office/point or safety office should also investigate if necessary. The investigation should either substantiate the claim or show doubt as to the validity of the claim.

.31 Some of the sources and expertise available during the investigation are:

a. Injured Employee

b. Witnesses

c. Immediate Supervisor and Unit Manager

d. Treating Physician

e. Safety Staff

f. Industrial Engineer

g. Inspection Service

h. Employee's Injury Compensation Case File(s)

i. Official Personnel Folder

j. Vehicle Accident Investigator

k. Law Enforcement Agency

.32 **Results of Investigation**

Based upon the results of the investigation, a determination will be made whether or not to controvert the claim. If the control office/point supervisor is confident that there is no basis for controversion, the claim and all supportive documentation will be immediately forwarded to the applicable OWCP District Office by the authorized control office. If the investigation reveals that there are questionable circumstances surrounding the claim, a controversion package will be prepared in accordance with Chapter 7 and forwarded with the claim, if possible, to the OWCP. The claimant must be notified verbally or in writing that the claim has been controverted. Either a copy of the notice or a memorandum for record will verify that the employee was notified of the controversion.

221.4 **Claims Package**

.41 Upon completion of investigation, the claims package will be prepared and forwarded to the appropriate OWCP District Office (Chapter 1, Subchapter 152) in a timely manner. The package must contain:

a. Properly completed Claim Form (CA-1, 2, or 2a)

b. Medical documentation

c. Supportive documents (witness statements, investigation reports etc.)

.42 **Delay of Claim**

The submission of the claim should not be unduly delayed. If medical reports and supportive information are not readily available, a cover letter and completed claim form will be forwarded to the OWCP in order for a claim number to be assigned and the processing of the claim to be initiated. All information and documents received by the control office/point will be held in a suspense file pending receipt of the claim number. It should be noted, however, that a complete claim package should be sent to the OWCP whenever possible. This will facilitate the adjudication process and allow for timely closure of the file.

221.5 Assignment of OWCP Claim Number

.51 CA-801

When the OWCP receives the claim form, a number will be assigned for control purposes. The OWCP will notify the claimant and control office/point via CA-801.

.52 Annotation of Records

Upon receipt of the CA-801, the control office/point will annotate the master log, case folder, and other appropriate logs with the claim number. The CA-801 will then be placed in an alphabetical card file or claim folder for reference. Any suspense and/or additional documents being held pending claim number assignment will be forwarded to the OWCP by placing the claim number in red ink in the upper right hand portion of the document and mailing it to the respective OWCP District Office.

221.6 Controversion of Traumatic Injury or Nonconcurrence of Occupational Disease/Illness or Recurrence (See Chapter 7).

.61 Controversion or Nonconcurrence Package

If it is determined that the claim or any portion thereof should be controverted, a controversion or nonconcurrence package will be prepared consisting as a minimum of the following:

a. Cover letter signed by the installation head or authorized official summarizing reason for controversion.

b. Exhibits - i.e. statements, investigative reports, photographs, etc.

.62 Submission of Package

The controversion package should be submitted to OWCP with the claim package, if possible. This will allow the OWCP to act upon the claim in a more timely manner. However, if elements of the controversion package are not readily available, the cover letter should state that initial investigation revealed doubt as to the validity of the claim and that further evidence will be submitted upon receipt. This evidence should then be forwarded as soon as possible in order to expedite the adjudication of the claim.

221.7 To Avoid Interruption of Pay When COP Ends

In noncontroverted cases, when an employee is unable to return to work at the end of a 45-day period of COP, apply the following OWCP procedures:

a. Provide Form CA-7, *Claim for Compensation on Account of Traumatic Injury,* to the employee after the 30th day. Instruct the employee to complete Part A and return the CA-7 to you within 7 days. Remind the employee of the need to support their claim with acceptable medical evidence of total disability for a job-related injury.

b. Forward the completed CA-7 with all relevant medical evidence to the OWCP by the 40th day. The employee may claim on the CA-7 the entire period of disability indicated on the physician's report, or 30 days, whichever is less.

c. If the disability is expected to continue beyond the period claimed on the CA-7, have the employee complete Form CA-8, *Claim for Compensation for Continuing Disability,* and send the completed CA-8 to OWCP at least 5 days prior to the expiration period covered by the CA-7. The CA-8 is normally submitted every 2 weeks. Continue this procedure until the employee returns to work (limited /regular duty) or until otherwise directed by OWCP.

d. When the employee returns to work, immediately notify OWCP by telephone and follow up with a completed Form CA-3, *Notification of Termination of Disability.* TELEPHONE NOTIFICATION IS CRITICAL TO PREVENT A POSSIBLE OVERPAYMENT BY OWCP.

221.8 Third Party Liability (See Chapter 8)

.81 Purpose

Whenever an employee sustains an injury or illness caused by a person who is not under the employ of the U.S. Postal Service or any branch of the federal government, an attempt should be made to recover all compensation costs from that party through the injured employee.

.82 Types of Third Party Involvement

.821 The following is a partial list of possible third parties that can have liability in certain cases:

a. The property owner on whose property a USPS employee was injured due to a safety hazard.

b. An animal owner whose animal bit a USPS employee.

c. The operator of a vehicle who was adjudged at fault in an accident causing injury to the postal employee.

d. The manufacturer or firm responsible for the manufacture or installation of a defective piece of furniture or equipment that failed and caused injury to a USPS employee.

e. Persons responsible for physical attacks or other assaults on a USPS employee.

.83 Form 2562

.831 In all cases where a third party has been identified as the likely cause of a traumatic injury to a USPS employee, the supervisor will enter the name and address of that party in block number 37 of CA-1 and have the employee or survivor complete a Form 2562, *Notice of Potential Third Party Claim*. This form notifies OWCP that a third party claim has been identified and that procedures will be taken (if appropriate for the USPS) to recover expenditures from that party. In cases where Form 2562 is submitted to OWCP, item 37 of the CA-1 must be checked "yes".

.832 In cases where a third party has been identified as the cause of an occupational disease, these claims will be forwarded to the Department of Labor (DOL) for recovery. Control office/point will be responsible for monitoring the progress of the DOL action until these cases are closed.

Chapter 3
Records Management

310 General

For proper control of claims, it is essential to establish an administrative system that accurately reflects the status of all claims at all times. This chapter deals with the preparation of files and forms, claim accountability and status, and maintenance of logs or registers for effective program administration.

320 Files and Form Preparation

321 Files

a. Upon notification that an injury/illness has occurred, prepare a file folder.

b. Folder: Should be of sturdy construction with two pronged fasteners on both sides. Do not use OPF Folders.

c. Label: Must have the following information:

1. Name.
2. Social Security Number.
3. Date of Injury.
4. Nature of Injury.
5. Type of Claim Filed.

Example:

Coleman, Ray DOI 6/15/84

SSN: 345-62-4829

Low Back

CA-1

d. Documents: Arrange documents chronologically, from bottom to top on the right side, with the claim form (CA-1 or CA-2) on the bottom. Place the claim control register on the left side of the folder.

e. Files:

1. Arrange file folders alphabetically according to employee names.

2. Maintain a separate folder for each injury/illness.

3. File recurrences (CA-2a's) with the original injury/illness file folder.

4. If an employee is reassigned, forward his file folder(s) to the new installation.

5. Number of Files: Maintain two separate files: one for current employees and one for former employees.

321.5 Retention of Folder

Maintain OWCP file folders in the inactive file at the injury compensation unit for five years after the employee has left the Postal Service. After five years, remove and place them in a shipping box. After the box is filled with folders, forward it to the nearest Federal Record Center. The folders will be kept there for 25 years.

322 Form Preparation

322.1 Prepare the following forms timely and accurately.

322.2 Form CA-1, *Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.* (Exhibit 3-1.)

.21 Purpose

Form CA-1 is the basic claim for a traumatic injury. It provides official notice to the employee's supervisor and OWCP that a traumatic injury has occurred.

.22 Time Requirement

The employee should complete and submit the Form CA-1 within 2 working days after the supervisor received notice of the injury. However, statutory time requirements will be met if the CA-1 is filed no later than 3 years after the injury. To be eligible for COP, the employee must file the CA-1 within 30 days from the date of injury.

.23 General Procedure

a. The employee's supervisor provides the employee a blank Form CA-1.

b. The employee completes items 1-16 and returns the form to the supervisor. NOTE: Form CA-1 may also be completed by someone acting on the employee's behalf, e.g., a friend or relative.

c. The supervisor gives the employee or the employee's representative a signed receipt.

d. The supervisor completes items 21-28 and 34-47 of the Form CA-1. The Injury Control Office/Point will complete items 29-33.

e. The supervisor prepares Form 1769, *Accident Report*.

f. The supervisor forwards the Form CA-1 to the control office.

.24 Forwarding to the OWCP

The CO reviews the CA-1 for accuracy and completeness and forwards it to the appropriate OWCP district office within 2 working days after it was received from the employee if one or more of the following conditions occur:

a. Employee loses time from work on any day following the injury date, whether the time from work is charged to leave or employee chooses continuation of pay.

b. Employee has sustained a traumatic injury which is likely to result in a medical charge against the compensation fund.

c. Prolonged treatment is indicated, even if the treatment is received on off-duty hours.

d. Disability may occur; or permanent disability appears likely.

e. Serious disfigurement of the face, head, or neck is likely to result.

f. If none of the above conditions occurs, file the original Form CA-1 in the employee's official personnel folder as a permanent record with a copy maintained in the CO. If the employee subsequently

seeks medical treatment and/or loses time from work, the Form CA-1 will be submitted in accordance with section 322.14 of this handbook.

g. Retain copies of all documents related to the claim (third party, rehabilitation, etc.) with the compensation file in the control office.

h. Forward a copy of all medical documentation associated with the claim file to the responsible postal medical unit.

.25 Step-by Step Instructions for Completing Form CA-1

a. The employee or the employee's representative fills out items 1-16 as follows.

1. Employee's last name, first name, middle name (enter "NMN" if no middle name).

2. Employee's date of birth - NOT TODAY'S DATE OR CURRENT YEAR.

3. Employee's sex.

4. Employee's social security number (nine digits).

5. Employee's complete home mailing address, including ZIP Code.

6. Employee's home telephone number with area code; if no home phone, enter "NONE".

7. Complete address of employing office/facility/installation.

8. EXACT location of injury; include address if off postal premises. Identify room, floor, work area, post number, stairway, platform, belt, etc.

9. Month, day, year, and time of injury. If injury occurred over a period of time during a single tour, enter the time span.

10. Month, day, and year the completed form is submitted. If mailed, the postmark is considered the date of submission.

11. The employee marks the appropriate box(es) -- a number is not required. If no dependents, "NONE" should be entered.

12. Employee's craft/title; and either FTRS, PTRS, PTFS, Casual, EAS, PCES, or other category.

13. Detailed description of how and why the injury took place. If the space on the form is insufficient, have the employee submit a more detailed statement on a separate sheet.

14. Description of the nature of injury and part(s) of body injured.

15. If the CA-1 is submitted to the supervisor more than two working days after the date of injury, the employee explains why in this item.

16. The employee must select either "a" or "b", even if there is no immediate time loss. The supervisor must explain the COP benefit to the employee and advise the employee that once a selection is made, it cannot be changed retroactively.

b. The supervisor is responsible for items 17-20.

17. If only one witness is identified, have the witness enter a statement here if the space is sufficient.

If the space is not sufficient, have the witness enter the statement on a separate piece of paper, attach that paper to the form, and enter the notation "see attached statement" here.

If multiple witnesses are available/identified, identify all the witnesses and enter the notation "see attached statements" here; attach the statements.

If the employee states that there were no witnesses, have the employee enter a statement similar to "There were no witnesses to my injury," and have the employee initial it.

18. Have these items completed as appropriate or enter "NA."

19. Have these items completed as appropriate or enter "NA."

20. Have these items completed as appropriate or enter "NA."

c. The supervisor fills out items 21-28 (and items 34-47).

21. Enter "USPS".

22. Name of office/facility/installation and unit the employee was assigned to at the time of injury. Include the agency code.

23. Complete address of the MSC/BMC injury compensation control office authorized to forward the CA-1 to the OWCP. (This address may or may not be the same as in Item 7.)

24. If employee has a fixed schedule, enter beginning and ending times.

If employee has a variable schedule, enter "VARIABLE" following "Regular Work Day" and the times the employee was scheduled to work on the day of injury (DOI). Enter "DOI" prior to "Begins."

25. If employee has a fixed schedule, enter the number of hours worked each day.

If employee has a variable schedule, enter "VARIABLE," and the number of hours worked on the DOI: For example, DOI = 6. The number of hours should agree with the schedule in Item 24.

26. If employee has a fixed workday schedule, circle the scheduled workdays.

If employee has a variable or rotating (carrier) schedule, enter either "VARIABLE" or "ROTATING," and circle the days worked or scheduled to work during the week of injury.

27. Enter the date and time of injury or date and time-frame during which the TRAUMATIC injury developed. If this item does not agree with Item 9, enter reason in Item 41 or on separate statement.

28. Enter the date the supervisor became aware of or was notified of the injury. This could be by visual (seeing the accident), verbal (being

told of the injury), written notice (receipt of the CA-1), etc.

d. The control office fills out items 29-33.

29. If employee does not stop work, enter **DID NOT STOP**.

Enter **DID NOT STOP** if employee stops work only for medical treatment (no disability involved) and either returns to complete the tour on which injured or returns at the beginning of or during the next scheduled tour.

NOTE: An employee could return during the next tour if initial medical treatment is not available until the next day or if next-day follow-up medical treatment is required. (Time used for medical treatment following the day of injury will be covered by COP.)

If employee is certified as disabled, enter the date and time of the first scheduled tour of duty missed following the day of injury.

NOTE: It is possible for the date that work stopped to be the same date that the injury took place if the injury occurred during a period of overtime immediately preceding the regular tour and that regular tour was not worked because of certified disability; or if the employee's tour began prior to midnight, the injury occurred after midnight, and the employee's next scheduled tour started later that day. Enter the employee's pay rate if lost time is involved.

30. Enter a date only if the employee enters a LWOP status; otherwise, enter "NA".

31. If no disability is involved, enter "NA".

If a disability is involved, this date may be the same date in Item 29; however, if the first day of disability is an off-day or holiday, the forty-five day period will begin on the off-day or holiday.

If the employee is not eligible for COP, i.e., the Form CA-1 was submitted to the supervisor more than thirty calendar days after the day of injury, enter "NOT ELIGIBLE."

32. Enter the employee's grade and step on the date of injury.

33. If there is no lost time involved (time used for medical treatment is not lost time), enter "NA." When this item is "NA," Item 29 should have DID NOT STOP.

If disability is certified, i.e., a date has been entered in Item 29, and the employee returns to work prior to submitting the CA-1 to OWCP, enter the date returned to work. If the employee has not returned to work, enter HAS NOT RETURNED.

e. The supervisor fills out items 34-47.

34. Enter full name of supervisor responsible for employee at the time of injury.

35. Was the person on-the-clock, on the assigned route, involved in horse play, sleeping on duty, etc.? If you cannot definitely state that the employee was or was not performing assigned duties at time of injury, enter "undetermined."

36. If it is possible to answer this item "yes" or "no," do so. However, if there is any possibility that a "yes" answer could not be substantiated upon investigation, enter "undetermined."

37. If there is clear evidence that a third party was not involved/responsible for the injury, check "NO."

If there is clear evidence that a third party was involved/responsible for the injury, check "YES", provide name and address of third party, and have the employee complete a Form 2562, *Notice of Potential Third Party Claim*. Help the employee complete this form, if necessary.

If there is no clear evidence, enter undetermined.

38. Obtain this data from the medical reports submitted by the employee, if available. If reports not available, enter "undetermined."

39. Enter the name and address of the physician who first provided treatment for the claimed work-related injury.

40. Refer to the most current medical reports.

41. When the supervisor has information which contradicts that provided by the employee, either verbal or written, check the "NO" block and provide all related evidence either in Block 41 or as an attachment. When an attachment is provided, enter "SEE ATTACHMENT." If there are no contradictions, check the "YES" block.

42. If information available clearly supports the claim, check "NO" and advise the employee that there will be no controversion.

If there is clear evidence that either the claim or COP should be controverted, check the "YES" block and advise the employee of your intent and reasons.

When a decision cannot be made at the time you complete this form, enter, "DECISION TO CONTROVERT PENDING INVESTIGATION." Coordinate your information/evidence with the control office.

If it is necessary to retain any injury-related information (CA forms, etc.) pending receipt of additional information or for any other purpose, safeguard such information against unauthorized access and maintain it in a locked drawer or cabinet.

43. Check appropriate block.

44. Enter date, if applicable.

45. Signature of supervisor completing this form.

46. Self-explanatory.

47. Self-explanatory.

322.3 Form CA-2, *Federal Employees' Notice of Occupational Disease and Claim for Compensation.* (Exhibit 3-2.)

.31 Purpose.

Form CA-2 provides official notice to an employee's supervisor and OWCP of an occupational illness/disease caused or aggravated by factors of employment. In addition to submitting this form the employee must furnish a narrative statement -- and supportive documentation -- explaining how the ailment was caused or aggravated by the work environment.

.32 **Time Requirement**

The employee should complete and submit the Form CA-2 within 2 working days after the supervisor received notice of the injury. However, statutory time requirements will be met if the CA-2 is filed no later than 3 years after the injury. It should be emphasized that the employee has the responsibility to provide all the necessary documentation as outlined in item 2 under "Instructions for Completing Employee's Portion of Form CA-2", prior to submitting to the official supervisor. Note: Occupational illness cases are not eligible for Continuation of Pay.

.33 **General Procedure**

a. The employee's supervisor provides the employee a blank Form CA-2.

b. The employee completes items 1-21 and returns the form to the supervisor. NOTE: Form CA-2 may also be completed by someone acting on the employee's behalf, e.g., a friend or relative.

c. The supervisor gives the employee or the employee's representative a signed receipt.

d. The supervisor completes items 22-50 with assistance from the control office.

e. The supervisor prepares Form 1769, *Accident Report*.

f. The supervisor forwards the Form CA-2 and a copy of the Form 1769 to the control office.

.34 **Forwarding to the OWCP**

The control office must forward all Forms CA-2 to the appropriate OWCP district office within 10 working days after these forms are received from the employee. However, upon first receiving a completed CA-2, the control office should coordinate with the supervisor and review all entries for completeness and accuracy of information. If the employee did not submit the required statement and medical reports, emphasize to the employee that failure to do so will either jeopardize the claim or greatly delay OWCP's adjudication process. If the employee insists on submitting the CA-2 without the supporting documentation, forward it to OWCP, within 10 working days after receiving these forms from the employee,

noting that the employee was advised to submit supporting documentation. When the claim is adjudicated, the control office must provide a copy of the decision to the Safety Office. This determines whether the injury/illness should be recorded in the National Accident Reporting System (NARS).

.35 **Retain copies of all materials submitted to OWCP with the compensation file.**

.36 **Step-by-Step Instructions for Completing Form CA-2**

a. The employee or the employee's representative fills out items 1-21 as follows.

1. Employee's last name, first name, middle name (enter "NMN" if no middle name).

2. Employee's date of birth - NOT TODAY'S DATE OR CURRENT YEAR.

3. Employee's sex.

4. Employee's social security number (nine digits).

5. Employee's complete home mailing address, including ZIP Code.

6. Employee's home telephone number with area code; if no home phone, enter "NONE".

7. Employee's craft/title and status (PTF, casual. etc.)

8. Complete address of employing office/ facility/installation.

9. Work location where illness developed.

10. If the disease/illness caused a period/ periods of disability certified by medical authority, complete as follows:

(1) If a single period of disability was caused, enter the **FROM** and **THROUGH** dates and the types of leave taken; include total hours.

(2) If multiple periods of disability were caused, enter **SEE ATTACHMENT** and have the employee list each period of disability, type of

leave taken, and the total number of hours taken for each type of leave.

If no disability/lost time was caused by the injury/illnesses, enter "NA".

11. Total earnings and the amount for each source, i.e., sick leave, annual leave, or earnings from outside employment. If income was received from other than the USPS, the source is to be identified, using an attachment if necessary. If NA was entered in item 10, NA should be entered here too.

12. The date that the employee first became aware of the disease or illness (may or may not be the same date that he realized that it was caused or aggravated by his employment).

13. The employee should be very specific. See item 12.

14. If an entry is required, be sure a specific reason is provided.

15. Description of the condition claimed to be work related. If a medical report is attached, make a reference to the report and the date of the report.

16. This item requires an entry. If the employee has ever applied for or received VA benefits, a, b, and c must be completed.

17. This item requires an entry. If the employee has ever applied for or received a retirement annuity under any federal retirement or disability law. If a "yes" answer is given, identify the type of action, e.g., disability retirement request or optional requirement request, and complete a, b, and c.

18. All relatives (including those adopted or pending adoption) who depend on the employee for support should be listed and the relationship identified. A spouse residing with the employee is considered a dependent. If a dependent child is not living at home due to attendance at a formal school, indicate "ATTENDING SCHOOL" and provide the mailing address of the school.

19. List a specific dollar amount paid out for support of children and others not residing with the employee. Indicate the amount paid out for each dependent. When payments are court ordered, a copy of the court order is required.

20. Be sure the normal signature is used.

21. This is the actual date the completed Form CA-2 is submitted to the supervisor.

NOTE: Be sure to instruct employee to furnish all information as required in instructions or adjudication of the claim might be delayed.

b. The supervisor fills out items 22-50 as follows.

22. "USPS".

23. Name of office/facility/installation of the employee at the time indicated in Item 12, and the OWCP agency code.

24. Complete address of the injury compensation control office, to the attention of the ICS authorized to forward the CA-2 to the OWCP. This address may or may not be the same as that in item #8.

25. This should be the supervisor responsible for the employee on the date in Item 12.

26. If the employee has a fixed schedule, enter beginning and ending times. If the employee has a variable schedule, enter **VARIABLE** following **Employee's Regular Day.**

27. If the employee has a fixed schedule, enter the number of hours worked each scheduled workday.

If the employee (such as a PTF or casual) has no fixed schedule, enter the average number of hours worked each workday, for example, **AVERAGES SEVEN HOURS.**

28. If the employee has a fixed schedule, enter the number of days scheduled to be worked each week.

If the employee (such as a PTF or casual) has no fixed schedule, enter "VARIABLE" and enter the

average number of days worked each week, for example, "AVERAGES SIX DAYS."

29. Obtain this data from the medical reports submitted by the employee, if available. If reports are not available, enter "UNKNOWN."

30. The name and address of the physician who first provided care for the claimed work-related injury.

31. Refer to the most current medical reports. Do not use verbal information received from the employee. If no medical reports are available, enter "No Report Available."

32. Specific date the supervisor was first notified of physical condition being related to employment. The supervisor should be identified since it could be a supervisor other than the one identified in either Item 25 or 48.

33. If no disability has been caused, enter **HAS NOT STOPPED.**

If a period of disability was caused by the claimed injury, enter the specific date and time the employee stopped work.

34. If the employee did not stop work, enter "NA."

If the employee was disabled due to the claimed injury and entered into a LWOP status commenced after the exhaustion of the employee's sick/ annual leave, enter the specific date and time the LWOP status started.

If the employee was disabled due to the claimed injury and used sick or annual leave throughout the period of disability, enter **NA, USED SICK/ANNUAL LEAVE.**

35. Based on the condition(s) identified as the cause of the injury in the employee's statement, determine if a specific answer is possible.

36. Self-explanatory.

37. If a casual or other type of temporary hire, enter "NO."

38. Enter total years/months of all civilian federal service.

39. If the employee did not stop work, enter NA, or coordinate with the control office.

40. If the employee did not stop work, enter NA, or coordinate with the control office.

41. If the employee did not enter a LWOP status, enter NA; if Item 34 has a date entered, complete as follows:

If the employee has a fixed schedule, circle the scheduled workdays.

If the employee has a variable or rotating (carrier) schedule, enter either VARIABLE or ROTATING.

42. NOTE: On some versions of Form CA-2, Item 42 has been misprinted as a second Item 41.

If the employee did not stop work, enter NA or coordinate with the control office.

A. Self-explanatory.

B. Self-explanatory.

C. Enter the last day of the pay period for which health benefits were deducted from the employee's pay. If the employee was not in a LWOP status long enough for health benefit premiums to stop, enter NOT INTERRUPTED.

43. If the employee did not stop work, enter NA.

If the employee did stop work due to the claimed injury:

(1) Enter the date and hour the employee returned to work following the disability period; or

(2) Enter "HAS NOT RETURNED" if disability continues beyond the date the CA-2 is submitted.

44. If the employee did not stop work, enter "NA."

If the employee did stop work and has not returned, enter "HAS NOT RETURNED."

If the employee did stop work and has returned, coordinate with control office.

45. If the employee did not stop work or has not returned to work, enter "NA."

If the employee returned to work after a period of disability with no change in schedule reflected in Item 41, enter "SEE ITEM 41."

If the employee returns to a work-week schedule other than that reflected in Item 41, see the instructions for item 41 above.

46. Complete this item only if the employee returned to work following a period of disability and the work assignment has changed. If so, describe the new duties and indicate if the assignment is a limited-duty assignment. If the work assignment has been changed to accommodate the claimed injury without a period of disability, so indicate.

47. If the supervisor takes exception to any information furnished by the employee in Items 1-21, identify the item(s) and explain the reason(s). Use an attachment if necessary. If not, enter"NA."

48. Signature of supervisor completing form.

49. Self-explanatory.

50. Self-explanatory.

C. Be sure to include statement commenting on employee's narrative statement as required by instructions.

322.4 Form CA-2a, *Notice of Employees' Recurrence of Disability and Claim for Pay/Compensation.* (Exhibit 3-3.).

.41 Purpose

The purpose of Form CA-2a is to report a recurrence of an earlier disability. An employee is considered to have such a recurrence when, after having returned to

work, he is again disabled and stops work as a result of the original injury or occupational disease.

.42 General Procedure

a. The employee notifies the supervisor of the recurrence.

b. The supervisor or the control office initiates Form CA-2a immediately upon receiving notice of a recurrence.

1. The supervisor or the CO always completes Part A, items 1-23. (Item 19 is based on information provided by the employee/representative.)

2. The control office completes Part B, items 24-27 only in the case of a recurrence of a traumatic injury and if the employee is entitled to receive and has requested COP for this recurrence.

c. The employee completes Part C, items 28-31 if requesting COP or compensation for this recurrence and/or if medical costs are involved. If the employee stops work because of this recurrence, he must either request COP -- provided qualifications are met -- or have the absence charged to sick leave, annual leave, or LWOP. The employee's representative will complete Part C, if the employee is unable to do so.

d. The employee writes a statement explaining the circumstances surrounding the current disability and why he believes it is related to the earlier injury or the occupational disease.

e. The supervisor forwards the Form CA-2a and the employee's statement to the control office.

f. The control office forwards the Form CA-2a, the employee's statement, controversion package -- if appropriate -- and related documentation to the appropriate OWCP district office.

g. Retain copies of all materials submitted to OWCP with the original compensation file.

.44 Step-by Step Instructions for Completing Form CA-2a

a. The supervisor or the control office completes Part A - Employer, items 1-23.

1. Employee's last name, first name, middle name (enter "NMN" if no middle name).

2. Employee's social security number (nine digits).

3. The OWCP file number for the original injury.

4. Employee's complete home mailing address, including ZIP Code.

5. Employee's home telephone number with area code; if no home phone, enter "NONE."

6. Complete address of employing establishment at time of original injury/disease. This entry should agree with either Item 7 of the original CA-1 or Item 9 of the original CA-2. Also enter the agency code.

7. Complete address of employing establishment at the time of the recurrence, if different from Item 6.

8. If recurrence of a traumatic injury, refer to Item 9 of the original CA-1.

If recurrence of an occupational disease/illness, refer to Item 13 of the original CA-2.

9. Month, day, year, and time employee first became aware of the recurrence, i.e., when the symptoms first become apparent. This entry will be derived from the information the employee provides for the completion of Item 19.

10. Enter the month, day, year, and time the employee stopped work because of this recurrence. If the employee stops work only to obtain medical treatment and returns to work following the treatment, this is not considered stopping work. If the employee does not stop work, enter "DID NOT STOP."

11. Enter a date only if the employee enters a LWOP status; otherwise, enter "NA."

12. Enter appropriate financial data.

13. If employee did not enter a LWOP status, enter "NA".

If the employee did enter LWOP status, complete this item as follows:

If employee has a fixed schedule, circle the scheduled workdays.

If employee has a variable or rotating (carrier) schedule, enter "VARIABLE" or "ROTATING."

14. If employee did not stop work, enter "NA" (check item 10 for agreement).

If employee did stop work due to the recurrence (check item 10 for agreement):

Enter the date and hour the employee returned to work following the period of disability.

Enter "HAS NOT RETURNED" if the employee has not yet returned.

15. Check "Yes" if a CA-16 was issued. If not, check "No".

16. This is the date the employee first obtained medical care following the recurrence.

17. This is the physician seen on the date entered in Item 16.

18. Check the "NO" box if applicable. Check the "YES" box if, following the original injury, the employee returned to work with a temporary or permanent work limitation, i.e., physical restrictions. Describe the type of work performed due to restrictions.

19. Complete this entry based on information received from the employee. Follow the instructions printed in this block carefully.

20. Self-explanatory.

21. Self-explanatory.

22. Self-explanatory.

23. Self-explanatory.

b. The control office completes Part B - Continuation of Pay, items 24-27, if the claim is for a

recurrence of a traumatic injury and the employee has COP benefits remaining. If there is no period of disability, all items will be "NA."

24. Enter the periods the employee received COP, including days off and holidays if the period of COP spans such days. If the employee has not yet returned to work, enter the first date of COP date after "From" and enter "CONTINUING" after "Through."

25. Enter appropriate figures.

26. Complete only if the employee's rate of pay changed during the period of COP.

27. Complete only if the employee's rate of pay changed during the period of COP.

c. The employee/representative completes Part C - Employee, items 28-31.

28. If the employee is claiming either COP or compensation (items 29 b and c) for this recurrence, he must show all income earned from non-USPS employment, including self-employment. If there was no such income, the employee must indicate "NONE."

29. If the recurrence does not result in a period of disability and this form is submitted only to cover medical expenses, 29 (a), (b) and (c) will be marked "NA."

If a period of disability is caused by this recurrence:

a. The employee may elect to use sick/annual leave to cover the period of disability. If the employee has already returned to work following the period of disability, enter the inclusive dates. Otherwise, enter the "From" date and enter "Continuing" after "Through."

b. If the period of disability is caused by the recurrence of a traumatic injury, the employee will select this block to request COP - if it is available and authorized - or compensation payments if COP is not available.

c. If the period of disability is caused by the recurrence of an occupational disease, the

employee will check this block to request compensation payments.

NOTE: If the original occupational claim has not been accepted by the OWCP when the recurrence is reported, no benefits are available until the OWCP decision is received.

30. Self-explanatory.

31. Self-explanatory.

322.5 Form CA-3, *Report of Termination of Disability and/or Payment.* (Exhibit 3-4.)

.51 Purpose

Form CA-3 is used to notify the appropriate OWCP district office that an employee's work disability has ended or that the employee has returned to work.

.52 General Procedure

The control office:

a. Immediately notifies the OWCP District Office by telephone only when the employee returns to duty and has been in a LWOP status and has requested compensation. Telephone notification is critical to help prevent overpayment by the OWCP.

b. In all cases of total disability, the ICP must forward a completed CA-3 to the OWCP when the employee returns to work (limited/regular duty).

c. Retains a copy of the CA-3 with the compensation file.

.53 Step-by-Step Instructions for Completing Form CA-3

The control office completes all items on this form.

a. Part A, General, Items 1-24

1. Employee's last name, first name, middle name (enter "NMN" if no middle name).

2. Employee's social security number (nine digits).

3. The OWCP file number. Check for correctness.

4. "USPS"

5. Name of office/facility/installation the employee was assigned to at the time of the disabling injury/illness.

6. Complete address of the control office authorized to forward the CA-3 to the OWCP. This address may or may not be the same as Item 5.

7. If the injury was traumatic, refer to Item 9 on Form CA-1.

If the injury/illness was occupational, refer to Item 13 on the CA-2.

8. If the injury was traumatic, refer to Item 29 on the CA-1.

If the injury/illness was occupational, refer to Item 33 on the CA-2.

9. If the injury was traumatic, refer to Item 30, on the CA-1.

If the injury/illness was occupational, refer to Item 34 on the CA-2.

10. Month, day, year, and time the employee returned to full-time duty. If total disability has been terminated and the employee has not returned to work, enter "HAS NOT RETURNED."

11. If the employee returns to his normal workweek:

If the injury was traumatic, refer to Item 26 on the CA-1;

If the injury/illness was occupational, refer to Item 13 on the CA-2 and enter the workweek which was in effect on the date indicated.

If the employee returns to a modified workweek due to limited duty assignment or due to a change in his normal workweek, enter the new workweek.

If the employee has not returned to work, enter "NA."

12. Enter the employee's pay rate on the day of return to work if it is different from that received on the date the disability began.

13. If, subsequent to the injury and prior to returning to work, the employee used sick/annual leave either in lieu of COP or pending approval of compensation payments, itemize such usage in 13 (a) and 13 (b).

14. Check "NO" if employee returned to normal duty without limitations.

Check "YES" if the employee returned to work and the work assignment was modified to accommodate the disability. If so, describe the new duties and indicate if they are for limited duty or a permanent modification to accommodate a permanent disability.

15. If the employee did not enter into a period of LWOP spanning at least one complete pay period, enter "NA."

If the employee was in a LWOP status spanning at least one full pay period, the employee must be notified and made aware of his responsibility for paying his own health benefit premiums. Provisions and procedures are outlined in ELM 525.

16. Verify with Personnel/OPF.

17. If the employee has not returned to work and if either the COP has been terminated or OWCP has been asked to terminate compensation payments, enter the appropriate details and attach pertinent documentation.

b. Part B, Continuation of Pay, Items 18-21

Complete Part B only if the employee was disabled due to a traumatic injury and received COP, unless all information was previously submitted on an OWCP Form CA-7. (The CA-7 is used to claim compensation payments when the disability continues beyond the forty-five day period.)

18. Enter the total period COP was paid. The date shown in the "From" block should agree with

Item 31 on the CA-1. The date shown in the "Through" block may be the following:

a. The day prior to the day the employee returned to full-time work; or

b. The forty-fifth day of COP; or

c. The day prior to the day COP was terminated for cause.

19. Enter appropriate monetary figure.

20. Complete these items only if the employee's rate of pay changed during the period of COP.

21. Complete these items only if the employee's rate of pay changed during the period of COP.

22. Person completing the form also completes these items.

23. Person completing the form also completes these items.

24. Person completing the form also completes these items.

322.6 Form CA-4, *Claim for Compensation on Account of Occupational Disease,* with attached Form CA-20, *Attending Physician's Report.* (Exhibit 3-5.)

.61 Purpose

a. Form CA-4 is used to claim compensation for time lost in occupational disease cases. (OWCP must have Form CA-2 on file in order to process the CA-4.)

b. Form CA-20 is used by the attending physician to make his report.

.62 General Procedure

a. The control office provides the employee a blank Form CA-4 with attached Form CA-20.

b. Employee or someone acting in employee's behalf prepares Items 1-12 of the CA-4 and returns it to the control office.

c. Control office detaches the forms from one another and completes items 1-4 of the CA-20 and items 16-33

of the CA-4. If the OWCP file number is known, enter it in the top right corner of the CA-4.

d. The control office sends the CA-20 to the attending physician (including a penalty envelope addressed back to the control office).

e. The control office sends the CA-4 to OWCP without delay after pay stops and pay was lost for more than 3 days.

f. The attending physician completes items 5-25 of the CA-20 and mails it in the penalty envelope.

g. The control office reviews the Form CA-20 and submits it to the appropriate OWCP district office.

h. Retain copies of all materials submitted to OWCP with the compensation file. Enter on control register.

j. Make periodic follow-ups to check the status of the case with OWCP.

.63 Step-by-Step Instructions for Completing Form CA-4.

a. The employee completes items 1-15.

1. Employee's last name, first name, and middle name (enter "NMN" if no middle name).

2. Enter the employee's social security number.

3. Enter the employee's OWCP number, if known.

4. Self-explanatory.

5. Self-explanatory.

6. If the disease/illness caused a period (s) of disability, and the disease/illness is certified by medical authority, complete as follows:

If a single period of disability occurred, enter "FROM" and "THROUGH" dates and the type of leave taken. Include total hours.

If multiple periods of disability were caused, enter "see attachment" and have the employee list each period of disability, type of leave taken, and the total number of hours taken for each type of leave.

If no disability/lost time was caused by the injury/illness, enter "NA."

7. Enter total earnings and identify the amount for each source, i.e., SL, AL, or earnings from outside employment. If income was received from other than the USPS, identify source. Use an attachment if necessary. If this is not applicable, enter "NA".

8. Self-explanatory.

9. Self-explanatory.

10. Check appropriate box. If not applicable, enter "NA." If "yes", fill out items A-C.

11. Check appropriate box. If not applicable, enter "NA."

12. Check appropriate box. If not applicable, enter "NA". If yes, identify the type of action, e.g., disability retirement request or optional retirement request.

13. All relatives (including those who are adopted) who depend on the employee for support should be listed and the relationship identified.

14. List specific dollar amount paid out for support of children and others not residing with employee. Indicate amount paid out for each dependent.

15. Employee's normal signature. Actual date the form was submitted to the control office.

b. The control office completes items 13-30.

16. Complete address of the injury compensation control office authorized to forward form to OWCP.

17. If no disability has resulted, enter "Has not stopped." If disability has resulted, enter specific date and time employee stopped work.

18. Compute weekly pay rate.

19. Compute any additional pay received for Sunday premium, or night differential.

20. If the employee did not enter a LWOP status, enter "NA".

If the employee did enter a LWOP status (Item 17 should have a date entered), complete as follows:

If the employee has a fixed schedule, circle the scheduled workdays.

If the employee has a variable or rotating schedule, enter either "variable" or "rotating."

21. Enter the beginning and ending date of any annual or sick leave used. If time loss was intermittent, attach a list of dates lost and leave status for each date. Enter in the "other" space any holiday leave, administrative leave or any paid leave category other than sick or annual leave.

22. Check appropriate box.

23. Enter "no" only if the employee is a casual or temporary.

24. If employee did not stop work, enter "NA". Otherwise, A, B, & C are self-explanatory.

25. Check appropriate box.

26. Month, day, year and time employee returned to work.

Enter "has not returned" if disability continues beyond the date the CA-2 is submitted.

27. Circle the scheduled workdays for the week in which the employee returns to work.

28. Enter the employee's pay rate on the day of return to work.

29. Check appropriate box. If yes, describe the new duties and indicate whether the assignment is a limited duty assignment.

30. If any information furnished by the employee conflicts with the supervisor's knowledge, identify the item(s) and explain the reason(s). Use attachment, if necessary. If there is no conflict, write "NA".

31. Signature of control office supervisor/specialist.

32. Self-explanatory.

33. Self-explanatory.

323 Additional Claim Forms

323.1 Form CA-5, *Claim for Compensation by Widow, Widower and/or Children.* (Exhibit 3-6.)

.11 Purpose

Form CA-5 serves as official notice to the OWCP of surviving widow's, widower's, and/or children's claim for compensation due to employee's death which resulted from job-related injury/illness.

.12 Time Requirements

a. Form CA-5 should be submitted to OWCP within 30 days of the death, if possible.

b. However, it must be submitted no later than 3 years after the death, except as noted below in c.

c. If death resulted from an injury for which a disability claim was timely filed, there is no time restriction on submission of the Form CA-5.

.13 General Procedure

a. The Control office provides a blank Form CA-5.

b. The widow, widower, children, and/or guardian of claimant(s) complete the CA-5. (All items on the CA-5 are self-explanatory.)

c. If it is a new case that has not been previously reported to OWCP, the supervisor completes Form 1769, Accident Report, and forwards it to the control office.

d. If death resulted from an injury/illness previously reported to OWCP, enter the OWCP file number on the upper right corner of CA-5.

e. Attempt to obtain copy of death certificate to be forwarded to OWCP.

f. Retain copies of all materials submitted to OWCP with the compensation file. The case file is retained in accordance with section 321.5.

323.2 **Form CA-5b, *Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.* (See Exhibit 3-7.)**

.21 **Purpose**

Form CA-5b serves as official notice to OWCP of eligible dependents' (parents, brothers, sisters, grandparents, and/or grandchildren) claim for compensation due to employee's death which resulted from job-related injury/illness.

.22 **Time Requirement**

Claim must be filed within 3 years following date of death.

.23 **General Procedure**

a. Control office provides a separate blank Form CA-5b to each claimant.

b. Each claimant completes a Form CA-5b (instructions are on on the back of the form) and returns it to the control office.

c. If death resulted from an injury/illness previously reported to OWCP, enter the OWCP file number on the upper right corner of CA-5b.

Note: A separate form is required for each person claiming benefits.

323.3 **Form CA-6, *Official Superior's Report of Employee's Death.* (Exhibit 3-8.)**

.31 **Purpose**

Form CA-6 serves as official notice to OWCP of an employee's job-related death.

.32 **General Procedure**

a. In the event of an employee's job-related death, the supervisor must immediately notify the ICS.

b. In all death cases, the control office will initiate Form CA-6.

c. After a thorough investigation by the ICS and the Safety Office of the circumstances surrounding the death, the ICS completes the Form CA-6.

d. If death resulted from an injury/illness previously reported to OWCP, the control office completes the Form CA-6, entering the OWCP file number on the upper right corner.

e. The control office submits the CA-6 to OWCP immediately.

f. Retain a copy in the case file. A closed case file is retained in accordance with section 321.5.

.33 **Step-by Step Instructions for Completing Form CA-6.**

1. Employee's last name, first name and middle name (if no middle name, enter "NMN")

2. Self-explanatory.

3. Self-explanatory.

4. Self-explanatory.

5. U.S. Postal Service.

6. City, State, and ZIP Code.

7. Name and address of injury compensation control office.

8. Self-explanatory.

9. Month, day, year and time of injury.

10. Month, day, year and time of death.

11. Date and hour employee's pay stopped. If employee was in a duty status at the time of death, the remainder of date of death is charged to administrative leave.

12. Enter detailed description of how injury occurred. Use attachment, if necessary.

13. Check appropriate box. If no is checked, explain fully.

14. Exact location of injury - street address, specific work area.

15. Self-explanatory.

16. Self-explanatory.

17. Enter employee's pay rate as of date of injury and date pay stopped.

18. Check appropriate box.

19. Enter "no" only if the employee was a casual or a temporary.

20. a. Enter the beginning and ending dates of any annual or sick leave used. If time loss was intermittent, attach a list of dates lost and type leave taken.

b. Enter the beginning and ending dates of any annual or sick leave used. If time loss was intermittent, attach a list of dates lost and type leave taken.

c. Enter any dates the employee received holiday leave, administrative leave or any paid leave category other than sick or annual leave.

21. If yes, complete a., b., & c.

22. Self-explanatory.

23. Enter the last day of the pay period in which health benefit deductions were made.

24. Indicate full name and complete address, including ZIP Code.

25. Self-explanatory.

26. Self-explanatory.

27. Self-explanatory.

28. Self-explanatory.

29. Self-explanatory.

30. Self-explanatory.

31. Self-explanatory.

32. Self-explanatory.

33. Self-explanatory.

323.4 Form CA-7, *Claim for Compensation on Account of Traumatic Injury,* with attached Form CA-20, *Attending Physician's Report.* (Exhibit 3-9.)

.41 Purpose

a. Form CA-7 is used to claim compensation for time lost due to a traumatic injury. OWCP should have Form CA-1 on file in order to process the CA-7. If Form CA-1 was not previously submitted, it should accompany Form CA-7 to OWCP.

b. Form CA-7 is also used to initiate a "scheduled award" or "leave buy-back".

.42 General Procedure

a. The control office provides the employee with a blank Form CA-7 with attached CA-20.

b. The employee or someone acting on the employee's behalf completes Part A (items 1-17) of the form.

c. The control office completes Part B (items 18-40).

d. The control office detaches the Form CA-20 from the Form CA-7.

e. The control office sends the CA-20 to the attending physician (including a penalty envelope addressed back to the control office).

f. The employee's attending physician completes the Form CA-20 and mails it in the penalty envelope.

g. ICP implements the following procedures when there is a possibility that an employee may not be able to return to work at the end of the 45-day COP period:

1. Provides the CA-7 to the employee after the 30th day and instructs the claimant to return the form within 7 days. The entire period of disability indicated on the physician's report may be claimed on the CA-7, or 30 days, whichever is less.

2. Forwards the completed CA-7 to the OWCP by the 40th day.

h. In controverted cases where pay is terminated for one of the 9 reasons listed on the instructional

portion of the CA-1, the ICP promptly prepares and submits the CA-7 to the OWCP, if the employee enters a LWOP status and claims compensation.

i. Retain copies of the Forms CA-7 and CA-20 with the compensation file. Enter on control register.

j. Check periodically with the OWCP to determine the current status of the claim.

.43 Step-by-Step Instructions for Completing Form CA-7.

a. The employee or employee's representative completes Part A (items 1-17).

1. Employee's last name, first name and middle name (if no middle name, enter "NMN").

2. Self-explanatory.

3. Self-explanatory.

4. If the employee has entered a non-pay status or is claiming leave buyback, enter "yes." If the CA-7 is submitted only for a scheduled award, enter "NO".

5. If the injury has resulted in a permanent loss of some part of the body or partial loss of function of some part of the body, enter "yes." The scheduled award will be based on the percentage of loss of function of body part affected. Compensation schedule is provided in Section 8107 of the FECA.

6. Beginning and ending dates of time lost due to injury.

7. Total amount of payment and inclusive dates for sick or annual leave, if applicable.

8. Check appropriate box. If yes, provide complete address, including ZIP Code.

9. Self-explanatory.

10. Self-explanatory.

11. Check appropriate box. If yes, provide other information requested in a., b., & c.

12. Check appropriate box. If yes, provide information in a., b., & c.

13. List all relatives (including adopted) who depend on the employee for support. A spouse living with the employee is considered dependent whether or not he/she financially depends on the employee.

14. List specific dollar amount paid out for support of children and others not residing with employee. Indicate amount paid out for each dependent.

15. Self-explanatory.

16. Self-explanatory.

17. Self-explanatory.

b. The control office completes Part B (items 18-40).

18. Enter name and complete address of the control office, including ZIP Code.

19. Enter pay rate as of the date of injury and as of the date employee stopped work.

20. Enter any additional pay received for Sunday premium, or night differential.

21. Circle the scheduled workdays for the week in which pay stopped. Enter "NA" if pay has not stopped.

22. Check appropriate box.

23. Enter "no" only if the employee is a casual or a temporary.

24. Include all federal civilian service.

25. a. Enter the beginning and ending dates of any annual or sick leave used. If time was intermittent, attach a list of dates lost and type leave taken.

b. Enter the beginning and ending dates of any annual or sick leave used. If time was intermittent, attach a list of dates lost and type leave taken.

c. Enter any dates the employee received holiday leave, administrative leave or any paid leave category other than sick or annual leave.

26. Compute weekly pay rate used for COP.

27. Enter the period or periods the employee received COP, including off-days and holidays if the period of COP spans such days.

28. Enter appropriate figures.

29. a. Complete these items only if the employee's rate of pay changed during the period of COP.

b. Complete these items only if the employee's rate of pay changed during the period of COP.

c. Complete these items only if the employee's rate of pay changed during the period of COP.

d. Complete these items only if the employee's rate of pay changed during the period of COP.

30. Enter month, day, year and time employee's pay stopped.

31. Enter beginning and ending dates of time lost due to the injury.

32. a & b Self-explanatory

a & b Enter last day of pay period in which health benefit deductions were made from employee's pay. Postal employees are no longer provided free health benefits coverage if employee is in LWOP for a entire pay period. See Postal Bulletin 21393, dated 3-3-83.

33. Enter month, day, year and time employee returned to work.

34. Indicate pay rate of employee upon return to work.

35. Circle scheduled workdays in which employee returned to work.

36. If employee has returned to a limited-duty assignment or another assignment as a result of the injury, describe the specific functions employee is performing.

37. If all entries completed by the employee or employee's representative are believed to be true, enter "N/A." If any item completed by employee conflicts with the supervisor's knowledge, identify the item(s) and explain the reason(s). Use attachment if necessary.

38. Signature of control office supervisor.

39. Self-explanatory.

40. Self-explanatory.

323.5 CA-8, *Claim for Continuation Compensation on Account of Disability,* with attached Form CA-20a, *Attending Physician's Supplemental Report.* (Exhibit 3-10.)

.51 Purpose

Form CA-8 is a claim for continuing compensation following submission of Form CA-4 or Form CA-7. The form is to be completed and submitted each pay period until the claimant returns to full-time duty or is placed on the periodic roll by OWCP. It must be completed when total disability for work extends beyond the period claimed on CA-4 or CA-7.

.52 General Procedure

a. The control office provides the employee with a blank Form CA-8 with attached Form CA-20a.

b. The employee or employee's representative completes items 1-15 of the CA-8, has the treating physician complete Form CA-20a, and returns both forms to the control office.

c. The control office completes items 16-24 of the Form CA-8 and submits CA-8 and CA-20a to the OWCP. The CA-8 should be forwarded to the OWCP at least 5 days prior to the expiration period covered by the CA-4 or CA-7. The CA-8 is normally submitted every two weeks. Continue this procedure until the employee

returns to work (limited/regular duty) or until otherwise directed by the OWCP.

e. Retain copies of all forms submitted to OWCP with the compensation file. Enter on control register.

.53 **Step-by-Step Instructions for Completing Form CA-8.**

a. The employee completes items 1-15.

1. Enter employee's last name, first name and middle name (if no middle name, enter "NMN".)

2. Enter employee's OWCP file number, if known. (The control office should verify this number.)

3. Enter employee's complete mailing address, including ZIP Code.

4. Self-explanatory.

5. Enter date and hour of injury/illness as shown on Form CA-1 or CA-2.

6. Enter beginning & ending dates. The beginning date should be the first day following the ending date of the previous claim. The ending date should be the day the form is signed.

7. Check appropriate box.

8. Check appropriate box.

9. a.- b. Complete only if any work was performed during the period claimed in item 6. Include self-employment or other jobs held. If no work was performed, enter "NA."

10. If not applicable, enter "NA."

11. Self-explanatory.

12. Enter information requested if the employee has applied for or received payments from the Veteran's Administration for a military-related disability.

13. If the employee has applied for or received an annuity from OPM, furnish information requested.

14. Self-explanatory.

15. Self-explanatory.

16. Enter month, day, year and time employee returned to work. If employee has not returned to work at the time the CA-8 is submitted, enter "has not returned."

17. If employee has not returned, enter "NA". Circle the scheduled workdays of employee.

18. Check appropriate box.

19. Self-explanatory.

20. Indicate any change in employee's health benefit plan/optional insurance coverage and explain reason for change.

21. Self-explanatory.

22. Signature of control office supervisor.

23-24. Self-explanatory.

323.6 Form CA-16, *Request for Examination and/or Treatment.* (Exhibit 3-11)

.61 Purpose

Form CA-16 is used to authorize an employee who claims a traumatic injury to obtain examination and/or treatment at a medical source of his choice. Such a medical source may be: Any duly qualified local physician, surgeon, osteopath, and -- within the scope of their specialty -- a podiatrist, dentist, clinical psychologist, optometrist, and (within certain limitations) a chiropractor.

.62 OWCP Approval

Form CA-16 is issued in traumatic cases only. The designated postal official will promptly authorize medical treatment by issuing the employee a properly executed CA-16 within 4 hours. It must not be issued for an occupational claim (Form CA-2) without prior approval by OWCP.

.63 General Procedure

a. The medical unit, the control office, or the designated control point completes Part A (items 1-13) of the Form CA-16 in duplicate, and gives the original to the employee (including a penalty envelope addressed to the control unit). Generally, supervisors may authorize a CA-16 only with prior authorization from the control office.

Note: "Limited Duty may be available" and may be stamped on the CA-16 provided to the attending physician.

The employee gives the original copy and the penalty envelope to the physician or treating medical facility.

c. The attending physician completes Part B (items 14-38) of the CA-16 and mails it in the penalty envelope.

d. Upon receiving the completed original CA-16 from the attending physician, the control unit forwards it to OWCP.

e. Retain a copy with the compensation file and provide a copy to the medical/health unit for the employee's medical file. Enter on control register.

.64 Step-by-Step Instructions for Completing Form CA-16

a. The control office or control point supervisor authorized to issue the CA-16 completes items 1-13. Obtain the required information from the forms completed by the employee and the employee's supervisor, or directly from the employee.

1. Enter the full name and address of the physician/hospital selected by employee only AFTER AN APPOINTMENT HAS BEEN MADE BY THE ISSUING AUTHORITY.

If issued to cover emergency care, enter the source of the emergency care and indicate "EMERGENCY CARE PROVIDED."

If issued due to a recurrence and if a CA-16 is authorized, the source of care should be the same that previously provided care -- to ensure continuity of treatment.

2. Employee's last name, first name, middle name (enter "NMN" if no middle name).

3. Enter date of original injury. See Item 9 on the CA-1 or Item 13 on the CA-2.

4. Enter the employee's craft/title and either FTRS, FTFS, PTRS, PTFS, Casual, Temporary, EAS, PCES, or other category.

5. Provide a DESCRIPTION of the injury. This information can assist the doctor. If traumatic, item 13 on the CA-1 may assist.

6. (a)- Check block "B (1)" if there is no doubt as to the validity of the injury.

(b) - Check block "B (2)" if there is doubt; or if issued in support of a CA-2.

7. If the CA-16 is issued for treatment of an occupational disease claim, enter the name of the OWCP official who authorized the CA-16. The approving official should be at least a claims examiner.

8. Identify the supervisor authorized to issue the form--the form must be signed.

9. Identify the supervisor authorized to issue the form--the form must be signed.

10. Self-explanatory.

11. Enter the date the CA-16 was issued.

12. Add the address of the servicing OWCP. (The control office will forward it to OWCP.)

13. Add the address of the control office authorized to process medical reports.

14-39. Must be completed by the treating physician.

323.7 Form CA-17, *Duty Status Report*. (Exhibit 3-12)

.71 Purpose

Form CA-17 is used in traumatic injury cases to provide the control office and OWCP with a brief interim medical statement concerning the employee's ability to return to full or limited duty.

.72 General Procedure

a. The issuing official completes items 1-9.

b. The employee gives the CA-17 (and generally, also a CA-16) to the attending physician.

c. The attending physician completes Part B of the CA-17 (items 10-21).

d. If the physician completes the CA-17 immediately, the employee may return it to the control office. (The physician mails the CA-16 in the penalty envelope provided.) However, a penalty envelope may also be provided for the CA-17 in case the physician decides to mail that form too.

e. Form CA-17 is issued for all medical treatment and to obtain interim status reports.

NOTE: "Limited Duty is available" may be stamped on the Form CA-17.

g. Upon receipt of the CA-17 from the attending physician, the control office determines whether the employee can return to full duty or is capable of performing limited duty assignment.

h. Retain the original CA-17 with the compensation file. Send a copy to OWCP. Enter on control register.

i. Send a copy to the Medical Unit for the employee's medical file.

.73 Step-by-Step Instructions for Completing Form CA-17.

a. The issuing official completes items 1-9.

1. Enter the same data reflected in Item 1 of the CA-16.

2. Enter the employee's last name, first name, middle name (enter "NMN" if no middle name).

3. Enter the date of original injury. See item 9 on the CA-1 or item 13 on the CA-2.

4. Enter the employee's position/title.

5. Enter the employee's social security number (NINE digits.

6. See items 13 and 14 on the CA-1 if a traumatic injury, or item 15 on the CA-2 if an occupational disease.

7. Complete a. and b. relative to the actual requirements of the employee's duties. Under "other", insert a brief description of the employee's functions.

8. Enter the address of the OWCP office. Tell the physician to send the CA-17 to the control office.

9. Enter the name and complete address of the control office.

b. The attending physician completes items 10-21. A physician's assistant, nurse practitioner, nurse, or other person not within the FECA definition of a physician is not acceptable as the certifying physician. However, certification by a physician's assistant will be acceptable if such certification is countersigned by a physician.

330 Registers, Logs, and Reports

331 Purpose

Accurate records (registers and logs) are essential in order to provide quick and easy access to the facts on a particular case or to provide vital information about the overall injury compensation program itself. Therefore, maintain at least the following logs and registers (of course, you may keep any others you feel are necessary).

332 Time Requirements

The following registers, logs, and reports are closed out at the end of each fiscal year, maintained in the control office for 10 years, and then destroyed.

333 Master Claim Log

This is a master journal of all claims filed. Set it up at the beginning of each Fiscal Year (FY) and close it out at the end of the FY. It provides information necessary for the preparation of various program reports and provides a quick reference for inquiries about date of injury, claim number, etc. Exhibit 3-15 provides a sample format. Keep claim activity for the

associate offices in a separate journal using the same format as the master log (Exhibit 3-16).

334 Claim Control Register

This is an individual case register placed on the left side of each case file. It provides an up-to-date picture of the status of the case. See Exhibit 3-17 for sample format.

335 Controversion Log

This is a separate log that contains information concerning the status of all controverted claims. It can immediately identify those claims that have been controverted and the decisions rendered. Sample format is in Exhibit 3-18.

336 Third Party Register

This log contains the cases which have third party involvement and potential for recovery of monies expended on behalf of the injured employee. See Exhibit 3-19 for sample format.

337 Rehabilitation Log

Enter any official referrals submitted by OWCP on Form Letter 8 (Exhibit 3-20a) in this log. This log is a quick reference that provides the current status of, and action taken on, referrals made to each office. This provides a cumulative account of all reference modes. See Exhibit 3-20 for suggested format.

338 Reports

338.1 Purpose

Various reports are necessary in order to provide information on the status of the Injury Compensation Program. These reports directly influence the direction of the Injury Compensation Program and therefore they must be accurate. The following reports are currently required:

a. Form 2572, *Injury Compensation Data Collection Report,* and Form 2572-A, *Injury Claims Analysis -- Update Worksheet* (statistics from these forms make up the Injury Claims Analysis System (ICAS) Report)

b. Chargeback Report

c. Workers' Compensation Injury on Duty Report (WC/IOD).

d. Rehabilitation Report

1. Information Retrieval and Injury System (IRIS).

2. OWCP Potential Rehabilitation Candidate Status Report (RCSR).

338.2 **Form 2572, *Injury Compensation Data Collection* (Exhibit 3-21)**

.21 **Preparation**

Form 2572 is prepared by the ICS or person responsible for managing injury claims. It is then reviewed by the installation head or highest available authority and submitted to the Regional Injury Compensation Program Administrator for input into the ICAS system by the Employee and Labor Relations Information Center (ELRIC). Preparation and disposition instructions are on the reverse of the form.

.22 **Accuracy and Timeliness**

It is essential to the success of the program that the statistics on Form 2572 be accurate and be timely submitted.

.23 **Purpose**

Since the ICAS report provides the overall statistical data necessary for proper administration of the Injury Compensation Program, it is perhaps the most important report required from control personnel. The data it supplies, along with that from other sources, provides information on the status of the program and serves as an indicator of where our efforts should be focused.

.24 **Form 2572-A, *Injury Claims Analysis - Update Worksheet*. (Exhibit 3-22).**

Use Form 2572-A (Rev. 6/85) to correct previous entries that need to be adjusted or corrected on Form 2572.

.25 **Instructions for Completing Form 2572**

For computer programming purposes, if no new data is entered in items 10-84, leave BLANK. Do not record

"0" under the heading "MSC No." Write in your finance number. This subheading will be corrected in a future printing.

Items 10-84. Extract this information from the Master Log on an AP basis with the log closed out the last day of each AP.

.26 Any written referral from the OWCP Rehabilitation Specialist is an official referral. Normally, the referral(s) will be on an OWCP-3 form. The number reported should include both former or current employees on LWOP/IOD who are officially referred to USPS by the OWCP. Do not count in your statistics any current employee who was not an official OWCP referral.

.27 Referrals previously reported in item 25 for which no management refusal or job offer will be made.

.28 Must have written approval from the region to be counted as official management refusal not to rehire.

.29 Number of actual job offers made during the reporting period.

.30 Number of those accepting job offer during A/P.

.31 Number of those selecting OPM/CSC retirement in lieu of job offer.

.32 Number of those declining/refusing job offer (includes those not responding within the time limit). This item must be adjusted if the job offer is accepted later or the individual has chosen OPM retirement.

NOTE: There must be no duplication of statistics in columns 31 and 32. Anything included in one of these columns must not be included in the other. Example: If individual opts for OPM retirement, do not count it as declining job offer. Report it only in item 31.

.33 Compile this cost using the cost avoidance formula . Include those that have returned to work, were placed on the rolls of OPM, or terminated from the rolls of the OWCP.

.35-37 Number of former or current (on LWOP/IOD) employees reemployed or reassigned without an OWCP referral. Specifically:

.35 Number actually returned to work.

.36 Number that declined job offer.

.37 Number selected OPM/CSC.

.38 Number of current employees working limited duty permanently reassigned due to a permanent partial disability for which medical accommodations have been made.

.39 Compensation cost reduction.

.40 Number of fitness-for-duty exams resulting in findings that agree with those of the treating physician.

.41 Number of fitness-for-duty exams resulting in findings that differ from those of the treating physician.

.43 Number of employees who have been separated from the rolls and who are drawing benefits from the OWCP.

.44 Number of employees separated with option to select OWCP payments in lieu of OPM annuity.

.45 Number of employees who have been found medically able to perform limited-duty during the A/P. Do not include those who were previously reported.

.46 Number of those in item 45 who were actually assigned limited duty during the A/P. Do not include those whose assignment to limited duty was reported previously.

.48 Number of personnel who received USPS Injury Compensation training during the AP (e.g., in house, PEDC, regional, Office of Training and Development, etc.)

.49 Number of personnel who received training from the OWCP during AP (i.e., seminars, 3-day course, etc.)

.51 Reviews of injury compensation program conducted at AOs during AP.

.52 Reviews of injury compensation program conducted at MSCs under the jurisdiction of the ICO during the AP.

.53 Number of cases officially referred in writing to the Inspection Service during AP (See Chapter 6).

.54 Referrals reported in item 53 which will not be jacketed or rejected.

.55 Number of cases accepted by IS for further investigation.

.56 Number of cases jacketed by the Inspection Service via written acknowledgment received during the AP. (See Chapter 6).

.58 Number of cases rejected due to lack of sufficient evidence to warrant further investigation.

.61 Controversions previously reported in item 61 which will not be upheld or denied.

.62 Decisions received on controverted cases during AP that were in favor of the USPS.

.63 Decisions received on controverted cases that were in favor of the claimant.

.65 COP hours avoided on cases in item number 62.

.66 COP costs avoided on cases in item number 62.

.70 Number of Forms 2562, *Notice of Potential Third Party Claim,* submitted during the AP.

.71 Number of cases identified in number 70 for which the OWCP is responsible (See Chapter 8).

.72 Number of recoveries made by the OWCP. (Form CA-162 or other acknowledgment of collection by the OWCP.

.73 Amount of recovery that was reimbursed to USPS and OWCP.

.74 Number of cases in item number 70 where the employee/attorney will pursue recovery.

.75 Number of recoveries made by the employee/attorney.

.76 Amount of recovery that was reimbursed to USPS and OWCP.

.77 Number of claims in item number 70 that were assigned to the USPS via Form 2577, *Assignment of Claim to the USPS.*

.78 Number of recoveries made on assigned cases.

.79 Amount of recovery that was reimbursed to the USPS and OWCP.

.80 Gross recovery amount on assigned cases.

.81 Number of actual refusals to pursue or assign by the employee.

.82 Cases in items 71, 74, and 77 where collection action was terminated without recovery.

.83 COP hours recovered either by OWCP, attorney/employee, or assignment.

.84 COP funds recovered either by OWCP, attorney/employee or assignment.

338.3 **Chargeback Report. (Exhibit 3-23)**

.31 **Purpose**

This report provides the MSC/BMC manager the information concerning costs of on-the-job injuries for current and former employees. The data is useful in budget planning, rehabilitation planning, and in evaluating the overall cost of the Injury Compensation Program.

.32 **Preparation**

This report is prepared by USPS Headquarters from data received from the U.S. Department of Labor. The report reflects payments by the Department of Labor to current and former USPS employees during the reporting period and includes compensation for wage loss, fatal benefits, and medical expenses.

338.4 **Workers' Compensation Injury on Duty Report. (Exhibit 3-24)**

.41 **Purpose**

This report provides information concerning COP and LWOP/IOD hours to the MSC/BMC Manager. This information must be reconciled against local timekeeping records to assure validity and accuracy. LWOP/IOD hours indicate possible long-term disability cases which should be monitored closely until the employee either returns to duty or is separated to the OWCP periodic rolls.

.42 **Preparation**

This report is prepared by the servicing PDC and reflects COP and LWOP/IOD hours used. The report

includes both an individual listing and collective summary by office, MSC, District, and Region.

338.5 Rehabilitation Tracking Report. (Formally titled Information Retrieval and Inquiry System (IRIS)) (Exhibit 3-25)

.51 Purpose

This report provides a national, regional, and individualized office summary of the number of current or former employees and the specific category to which reemployed or reassigned.

.52 Preparation

This report is prepared by ELRIC each accounting period to show the cumulative number of individuals reemployed through the USPS Rehabilitation Program.

338.6 OWCP Potential Rehabilitation Candidate Status Report (RCSR). (Exhibit 3-26)

.61 Purpose

This is an automated report designed to monitor rehabilitation activities at all management levels through ELRIC. It replaces inadequate manual reports and provides the assurance that claimants who returned to work, transferred to OPM annuity, or declined a valid job offer have been removed from OWCP rolls.

.62 Preparation

The RCSR reporting system obtains its initial information from chargeback reports. The Injury Compensation Supervisor/Specialist is responsible for providing rehabilitation data (on an AP basis) of any action taken on the candidates that appear on the report and also adding new rehabilitation candidates as they are identified.

350 Form 2573, *Inquiry on Claim Status.* (Exhibit 3-27)

351 Purpose

To obtain current status of a claim that has been submitted to OWCP, the installation head or authorized designee can initiate Form 2573, *Request--OWCP Claim Status:*

a. Complete Section A and include the claimant's OWCP file number; check off the information wanted from OWCP in Section B.

b. Send two copies to the OWCP district office.

c. The OWCP office returns a copy to the requesting official with the pertinent information requested.

360 Injury Compensation Records Access and Disclosure Guidelines

361 Types

There are three types of injury compensation program records maintained in control offices:

(1) Injury compensation case files.

(2) Injury compensation claim status records.

(3) Injury compensation program administrative and general office records.

362 Injury Compensation Case Files

Prepare and maintain an injury compensation case file for each injury or illness for which compensation is claimed. The case file is to consist of copies of Department of Labor forms, Postal Service forms, relevant medical information supplied by physicians, claim-related correspondence, and other sensitive information that specifically relates to the injury or illness. These records are part of Postal Service Privacy Act System 120.098. Accordingly, Postal Service Privacy Act regulations apply (See ASM 353).

363 Injury Compensation Claim Status Records

These records consist of the logs and registers that relate to the status of claims submitted to OWCP for processing; and logs and registers of controversions and third party liability claims. These logs and registers contain information which is retrievable by individual identifiers, i.e., employee name, social security number, etc., and as such are also considered part of Privacy Act System 120.098. Privacy Act regulations apply to these records as well.

364 Injury Compensation Program Administrative and General Office Records

These are documents related to the general administration and internal operations of the injury compensation control office, including subject files, general correspondence, directives and reports. Since these records do not contain individually identifiable information, privacy regulations do not apply.

365 Responsibility

365.1 Installation Head

The postal installation head is the official custodian of the records in that installation; (with the exception of restricted medical records maintained in medical facilities) and he or she is responsible for ensuring compliance with Postal Service regulations and instructions pertaining to such records.

365.2 Injury Compensation Control Personnel

The Injury Compensation Control Office/Point individual, as the designee of the installation head (and/or other individuals specifically designated by the installation head if injury compensation personnel are unavailable) is responsible for the maintenance, disposition, and disclosure of injury compensation program records. Accordingly, this individual makes records access and disclosure decisions on injury compensation matters and must be familiar with USPS Privacy Act regulations. This individual is responsible for determining what information from OWCP case files or claim status records is relevant to satis- fying a request for information. In the event of a dispute, the injury compensation personnel will contact the installation head for guidance. On occasion, injury compensation personnel may consult with a medical officer before releasing information from these records.

366 Access and Disclosure Guidelines

366.1 Protection of Records

All records related to an employee's injury or illness are sensitive and must be protected from unauthorized access and disclosure. These records must be maintained in locked file cabinets in the exclusive custody of injury compensation personnel (or those individuals specifically designated by the

installation head). Access to these records is limited to those individuals with a need to know. Disclosure is made directly from the injury compensation personnel to the requester.

366.2 Employee's Access to Own Records

An employee may review and have copies of any information pertaining to himself contained in an injury compensation case file with the following qualification: Any medical information which -- in the opinion of the injury compensation personnel -- does not relate directly to a job-related injury or illness will not be directly disclosed to the employee without the approval of the medical officer responsible for the installation. If the medical officer decides that disclosure would be likely to affect the employee adversely, the record will be sent only to a physician designated in writing by the employee. In such a case a disclosure accounting must be filed (See section 223.22 of Handbook EL-806, *Health & Medical Services.*)

Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
PARKER, JOHN EDWARD	10/8/25		258-23-2210

5. Employee's Home Mailing Address (no., street, city, state, zip code)	6. Home Telephone
615 TUCKER LANE STAUNTON, VA 24401	Area Code: 703 Number: 860-4512

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
U.S POSTAL SERVICE 1430 N. AUGUSTA STREET STAUNTON, VA 24401 ATTN: MARK FISHER	LOADING DOCK OF POST OFFICE- STAUNTON, VA

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
12/19/82 ☒ AM ☐ PM	12/19/82	Wife/Husband ☑ Children/Under 18 Years Old ☐	MAIL CLERK

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Lifted case of mail to putting truck	LOWER BACK

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or Annual leave.

☒ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

John Edward Parker
Signature of Employee or Person Acting on His/Her Behalf

PENALTY PROVISION: Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate U.S. Criminal Code provisions, be punished by a fine of not more than $10,000 or imprisonment for not more than five years, or both.

17. Statement of Witness (Describe what you saw, heard or know about this injury)

I saw Mr Parker transfer a case of mail to putting truck when he shouted that he hurt his back.

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)
Paul Hodges	450 TURNER ROAD Staunton, VA 24401	12/19/82

Form CA-1
Rev. Oct. 1983

Exhibit 3-1

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency: U.S. POST OFFICE

22. Bureau or Office: STAUNTON, VA 24401 Agency Code: 1233

23. Name and Address of Reporting Office (No., street, city, state, Zip Code): Injury Compensation Unit U.S. POST OFFICE 1430 N. AUGUSTA St. Staunton, VA 24401 Attn: MARK FISHER

24. Regular Work Day — Begins: 730 ☒ AM ☐ PM; Ends: 4 ☐ AM ☒ PM

25. Number of Hours Worked Per Day: 8

26. Circle Days Paid Per Week: S (M) T W T (F) S

27. Date and Hour of Injury (mo., day, year): 12/19/82 10 ☒ AM ☐ PM

28. Date Reporting Office Received Notice of Injury (mo., day, year): 12/19/82

29. Date and Hour Stopped Work (mo., day, year): 12/19/82 11 AM; Pay Rate $ 19,800 per yr

30. If Pay Has Been Terminated, Give Date (mo., day, year): NA

31. 45 Day Period Begins (mo., day, year): 12/20/82

32. Employee's Grade and Step on Date of Injury: Grade 5 Step 4

33. Date and Hour Employee Returned to Work (mo., day, year): 1/10/83 730 ☒ AM ☐ PM

34. Name of Supervisor at Time of Injury: Robert O'Neill

35. Was Employee in Performance of Duty At The Time of Injury? ☒ Yes ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self of Another? ☐ Yes ☒ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☒ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury (mo., day, year): 12/19/82

39. Name and Address of Physician First Providing Medical Care: FREDERICK SNYDER M.D. CALVIN COOLIDGE HOSPITAL STAUNTON, VA 24401

40. Do Medical Reports Show Employee is Disabled For Work? ☒ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? ☒ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☒ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions:
- ☐ No Lost Time and No Medical Expense. Place This Form In Employee's Official Personnel Folder.
- ☒ Medical Expense Incurred or Expected. Forward This Form To OWCP.
- ☒ Lost Time Covered By Leave, LWOP, or COP. Forward This Form To OWCP.

44. All Information Requested On This Form Has Been Furnished. If Not, It Will Be Submitted By 12/23/82 (CA-16) (Fill in Date)

45. Signature of Supervisor: Robert O'Neill

46. Title and Office Phone Number: Supervisor, Mails 703/860-2480

47. Date (mo., day, year): 12/20/82

PENALTY PROVISIONS: An immediate superior who hinders the filing of any compensation claim or report may be punished by a fine of not more than $500 or imprisoned not more than one year, or both – 18 U.S.C. 1922. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact in respect to this claim may also be subject to appropriate felony criminal prosecution.

Exhibit 3-1

INSTRUCTIONS FOR COMPLETING FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

IMPORTANT: The employee and official superior (supervisor) should read all of the following instructions before completing this form.

1. The employee, or someone acting on his/her behalf, shall complete Items 1 through 16 and give the form to the employee's supervisor for completion of items 21 through 47. The employing agency shall ensure that all evidence bearing on the injury is submitted to OWCP and that such additional evidence is submitted with the notice of injury or within the time indicated in Item 44.

2. Upon receiving the completed form the supervisor shall complete "Receipt of Notice of Injury" at the bottom of this page, detach the page and give it to the employee. The supervisor is also responsible for obtaining the witness information in Items 17 through 20.

3. Upon completion of items 21 through 47, the supervisor should advise the employee whether pay will continue or will be controverted and terminated. If pay is controverted and stopped, the supervisor shall explain to the employee the basis for the action.

4. Where pay is continued, the employing agency may require medical evidence, via Form CA-17, Duty Status Report, as often as circumstances indicate.

5. Form CA-1, fully completed, shall be forwarded to the appropriate OWCP District Office within two working days following receipt by the supervisor if:

   a. The injury causes disability for work beyond the day or shift it occurred, or

   b. It appears that the injury will result in prolonged treatment, permanent disability or serious disfigurement of the head, face, or neck, or

   c. The injury has resulted, or appears it will result, in a charge for medical or other related expenses.

If none of the above occurs or appears likely, the form shall be retained in the employee's official personnel file.

6. **NOTE**: The employing agency may properly controvert and terminate the employee's pay if:

   a. Disability results from an occupational disease or illness; or

   b. The employee is excluded by 5 USC 8101 (1) B or E; or

   c. The employee is neither a citizen nor a resident of the United States or Canada; or

   d. The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties; or

   e. The injury was caused by the employee's willful misconduct, intent to bring about injury or death of self or another person, or was proximately caused by employee's intoxication; or

   f. The injury was not reported on Form CA-1, within 30 days following the injury; or

   g. Work stoppage first occurred six months or more following the injury; or

   h. The employee initially reported the injury after his/her employment has terminated; or

   i. The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs or other similar groups.

7. If additional space is required to explain or clarify any point, attach a supplemental statement to the form.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION

RECEIPT OF NOTICE OF INJURY

THIS ACKNOWLEDGES RECEIPT OF NOTICE OF INJURY SUSTAINED BY John Edward Parker.
(Name of injured employee)

WHICH OCCURRED ON 12/19/82 (Mo., day, year) AT Staunton, VA Post Office (Location)

SIGNATURE OF OFFICIAL SUPERIOR	TITLE	DATE (Mo., day, year)
Robert O'Neill	Supervisor, Mails	12/19/82

Form CA-1
Rev. Oct. 1983

Exhibit 3-1

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

FEDERAL EMPLOYEE'S NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

NOTE: All information and evidence requested on the attached instruction sheet should accompany this form or adjudication of the claim will be delayed.

1. Name (Last, first, middle)	2. Date of Birth (Mo., day, year)	3.	4. Social Security Number
BROWN, ANN MARIE	7/22/51	☐ Male ☒ Female	579-02-3840

5. Home Mailing Address	6. Home Telephone Number (Including Area Code)	7. Occupation
415 CHESTNUT ST CHICAGO, IL 60709	312-886-6021	DISTRIBUTION CLERK

8. Name and Address of Employing Agency	9. Location where you Worked When Disease or Illness Occurred
US POSTAL SERVICE CHICAGO, IL 60699	REGISTRY SECTION MAIN POST OFFICE BLDG CHICAGO, IL

10. If you lost pay, show period compensation is claimed (Mo., day, year)	11. Show amount of all wages received from any source during period shown in item 10. Also give employer's name and address if other than Federal Government.	12. Date you first became aware of disease or illness (Mo., day, year)
From: 9/2/80 Through: PRESENT	$ NA	8/20/80

13. Date you first realized the disease or illness was caused or aggravated by your employment (Mo., day, year). Explain why you came to this realization. 9/8/80 I WAS ADVISED BY MY DOCTOR THAT I WAS NOT TO WORK BECAUSE OF MY High blood pressure AND ANXIETY

14. If this notice and claim was not filed with the employing agency within 30 days after date shown in item 13 above, explain reason for the delay.	15. Nature of the disease or illness (e.g. pulmonary tuberculosis, coronary heart condition, etc.)
NA	WORK RELATED STRESS

16. Have you ever applied for or received benefits from the VA based on service in the Armed Forces of the United States? ☐ Yes ☒ No If Yes, furnish →	a. Claim No.	b. VA address where claim is filed.	c. Nature of disability and monthly payment. $

17. Have you applied for or received an annuity under the U.S. Civil Service or other federal retirement or disability law? ☐ Yes ☒ No If Yes, furnish →	a. Claim No.	b. Date annuity began (Mo., day, year)	c. Amount of monthly payment $

18. List your dependents. (Includes husband or wife living with employee)

Name	Relationship	Date of Birth	Living with You (Yes-No)	Mailing Address, if Different From your own
NA				

19. Show amount paid each month for support of dependents not living with you $ NA
State whether payments were ordered by a court, and if so, attach a copy of the court order.

I certify that the disease or illness described above was a result of my employment with the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

20. Your signature or signature of person acting for you	21. Date (Mo., day, year)
Ann M. Brown	9/15/80

Form CA-2
Rev. May 1975

Exhibit 3-2

OFFICIAL SUPERIOR'S REPORT OF OCCUPATIONAL DISEASE

22. Department or Agency: US POSTAL SVC

23. Bureau or Office: Agency Code: 5815 — CHICAGO, IL 60699

24. Name and Address of Reporting Office (No., street, city, state, ZIP code): INJURY COMPENSATION Office, ATTN: JOB CLAIM, US POSTAL SVC, CHICAGO, IL 60699

25. Name of Supervisor when Employee Contracted Disease or Illness: ZACK JONES

26. Employee's Regular Day: Begins 6 ☒ AM ☐ PM; Ends ☐ AM 2:30 ☒ PM

27. Number of Hours Worked Per Day: 8

28. Number of Days Worked Per Week: 5

29. Date Employee First Obtained Medical Care for Disease or Illness (Mo., day, year): 8/24/80

30. Name and Address of Physician First Providing Medical Care: Clone Brown MD, Suite 6, Medical Bldg, 180 Ohio Drive, Chicago, IL 60606

31. Do Medical Reports Show Employee is Disabled for Work? ☒ Yes ☐ No

32. Date Employee First Reported Condition to Supervisor (Mo., day, year): 9-2-80

33. Date and Hour Employee Stopped Work (Mo., day, year): 9-2-80 — 6 ☒ AM ☐ PM

34. Date and Hour Employee's Pay Stopped (Mo., day, year): 9-5-80 — 6 ☒ AM ☐ PM

35. Date Employee was Last Exposed to Conditions Alleged to Have Caused Disease or Illness (Mo., day, year): 9-1-80

36. Did Employee Work in the Position a Full Eleven Months Prior to Stopping Work Due to the Disease or Illness? ☒ Yes ☐ No

37. If Answer to Item 36 is No, would the Position Have Provided Employment for a Full Eleven Months, Except for the Disease or Illness? NA ☐ Yes ☐ No

38. Total Length of Employee's Federal Civilian Service (Years and months): 6 YRS 11 Mos

39. Pay Rate at the Time Employee Stopped Work: a. Base Pay $22,000; b. Subsistence; c. Quarters; d. Other

40. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify and Show Amount: Type: NA $ Per

41. Circle Days Worked Per Week When Pay Stopped, If Other Than Monday Through Friday: S (M T W T F) S

41. Deductions

	Health Benefits	Optional Life Insurance
A. Was employee enrolled on date pay stopped?	☒ Yes ☐ No	☐ Yes ☒ No
B. If Yes, furnish code number.	1 1 2	
C. If Yes, give month, day, year, through which deductions were made.	( )	( )

43. Date and Hour Employee Returned to Work (Mo., day, year): HAS NOT RETURNED ☐ AM ☐ PM

44. Pay Rate at Time Employee Returned to Work: $ NA Per

45. Work Week on Return to Work if Other Than Monday Through Friday: NA (S M T W T F S)

46. If Employee Has Returned to Work and Work Assignment has Changed, Describe New Duties: HAS NOT RETURNED

47. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

48. Signature of Supervisor: Zack Jones

49. Title and Office Phone Number: 312-886-7714 Supervisor of Mails

50. Date (Mo., day, year): 9/22/80

*USGPO: 1976 — 653-560

Exhibit 3-2

DISABILITY BENEFITS FOR EMPLOYEES UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

The FECA, administered by the Office of Workers' Compensation Programs (OWCP) provides the following general benefits for employment-related occupational disease or illness:

1. Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

2. Payment of compensation for total or partial wage loss.

3. Payment of compensation for permanent impairment of certain organs, members or functions of the body (such as loss or loss of use of an arm, kidney, loss of vision, etc.) or for serious disfigurement of the head, face or neck.

4. Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Civil Service Commission's Federal Personnel Manual.

RECEIPT OF NOTICE OF DISEASE OR ILLNESS

This acknowledges receipt of notice of disease or illness sustained by Ann M. Brown
(Name of injured employee)

I was first notified about this condition on 9-2-80 (Mo., day, year) at Main Post Office, Chicago, IL 60699 (Location)

Signature of Official Superior	Title	Date (Mo., day, year)
Zack Jones	Supervisor of Mails	9-15-80

CA-2
Rev. May 1975

Notice Of Employee's Recurrence Of Disability And Claim For Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

IMPORTANT: Before completing this form please read carefully the instructions.

PART A – EMPLOYER

1. NAME OF INJURED EMPLOYEE (last, first, middle)	2. SOCIAL SECURITY NUMBER	3. OWCP file number for original injury (if known)
Gray, Deborah Ann	223-45-8017	A41 - 13852

4. HOME MAILING ADDRESS (include zip code)	5. HOME TELEPHONE
6059 Maple Avenue Baltimore, MD 21207	Area Code 301 Number 724-5934

6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury (number, street, city, state, zip code)	7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrence, if other than 6.
U.S. Postal Service Injury Compensation Unit Attn: William Parks Baltimore, MD 21210	Same

8. DATE AND HOUR of original injury (mo., day, year)	9. DATE AND HOUR of recurrence (mo., day, year)	10. DATE AND HOUR stopped work following recurrence (mo., day, year)	11. DATE AND HOUR pay stopped following recurrence (mo., day, year)
7/14/82 ☒ a.m. ☐ p.m.	3/15/83 2 ☐ a.m. ☒ p.m.	3/15/83 2 ☐ a.m. ☒ p.m.	Has Not ☐ a.m. ☐ p.m.

12. PAY RATE IN EFFECT ON:	a. Base pay	b. Subsistence	c. Quarters	d. Other pay
A. Date of Recurrence	$ 10.55 per hour	$ NA per	$ NA per	$ NA per
B. Date Stopped Work Following Recurrence	$ 10.55 per hour	$ per	$ per	$ per

13. Show work week at time pay stopped, if other than Monday thru Friday	14. DATE AND HOUR returned to work, following recurrence (mo., day, year)	15. At time of recurrence did official superior authorize medical treatment?
S M (T W T F S)	Has Not ☐ a.m. ☐ p.m.	☒ YES ☐ NO

16. DATE employee first received medical treatment following recurrence (mo., day, year)	17. NAME AND ADDRESS of physician treating employee following recurrence
3/15/83	Randall Smith, MD 6853 Harbor Drive Baltimore, MD 21234

18. After returning to work following the orignial injury, was the employee handicapped or in any way limited in performing his/her usual duties? ☐ YES ☒ NO *(If yes, explain)*

19. Describe the circumstances of the recurrence of disability as reported by the employee. If the condition gradually worsened over a period of time, describe the progress of the condition from the time employee returned to work up to the date of recurrence.

Reeurrent back problems were reported by the employee

A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

20. Signature of official superior (at time of recurrence)	21. Title	22. Official superior's work phone number	23. Date (mo., day, year)
Joseph Larson	Foreman, Mails	724-4204	3/19/83

Form CA-2a
Revised February 1984

Exhibit 3-3

PART B – CONTINUATION OF PAY

24. Inclusive dates that employee's regular pay continued during this period of recurrence. Do not include period of sick or annual leave. *(mo., day, year)*	25. Show gross dollar amount of regular pay which employee received during this period of recurrence.
From: NA Through:	$

26. If pay changed during the period employee was receiving continuation of pay, for this recurrence, show date of change *(mo., day, yr.)*.	27. If pay rate changed during the period employee was receiving continuation of pay, give new rate.			
	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(specify)*
NA				

PART C – EMPLOYEE

28. Complete this item if you worked during the period shown in item 29(b) or 29(c).

a. Dates & Hours Worked	b. Pay Rate *(per hour, day or week)*	c. Total Amount Earned	d. Type Work Performed	e. Name & Address of Employer
NA				

29. I certify that the recurrence claimed on date in item 9 was due to the injury shown in item 8 and I hereby claim medical treatment, if needed, and the following as checked below, while disabled for work:

☒ a. Sick and/or annual leave

Period: From: 3/15/83 Through: ?

☐ b. Continuation of regular pay not to exceed 45 days, which will include days taken during the original injury and prior recurrence(s), and compensation for wage loss if disability for work continues beyond 45 days. *(If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).*

Period: From: Through:

☐ c. Continuing compensation on account of occupational disease.

Period: From: Through:

30. Signature of Employee or Person Acting on his/her behalf. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.	31. Date *(Month, day, year*
Deborah Grey	3/19/83

Exhibit 3-3

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

REPORT OF TERMINATION OF DISABILITY AND/OR PAYMENT

PART – A GENERAL

1. Name of Injured Employee (*Last, first, middle*)	2. Social Security Number	3. OWCP File Number (*If known*)
Parker, John Edward	258-23-2210	A16-4082

4. Department or Agency	5. Bureau or Office
U.S Postal Service	Staunton, VA 24401

6. Name and Address of Reporting Office (*Include Zip Code*)
U.S Postal Service Injury Compensation Unit 1430 N. Augusta Street Staunton, VA 24401 ATTN: MARK FISHER

7. Date and Hour of Injury (*Mo., day, year*)	8. Date and Hour Stopped Work (*Mo., day, year*)	9. Date and Hour Pay Stopped (*Mo., day, year*)	10. Date and Hour Returned to Work (*Mo., day, year*)
12/19/82 10 ☒ AM ☐ PM	12/19/82 11 ☒ AM ☐ PM	NA ☐ AM ☐ PM	1/7/83 7:30 ☒ AM ☐ PM

11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday
S (M T W T F) S

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work. NA

a. Base Pay	b. Subsistence	c. Quarters	d. Other (*Specify*)

13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

a. Annual Leave	b. Sick Leave	c. Other (*Specify*)
From: NA Through:	From: NA Through:	From: NA Through:

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?
☐ Yes ☒ No If Yes, Describe The Type of Work Employee Is Performing.

15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (*Mo., day, year*)
Health Benefit NA Optional Insurance

16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (*Mo., day, year*)
Number NA Date

17. Remarks:

PART – B CONTINUATION OF PAY

18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (*Mo., day, year*)
From: 12/20/82 Through: 1/6/83

19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick or annual leave.
$876.45

20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (*Mo., day, year*) NA

21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay, Give New Rate

a. Base Pay	b. Subsistence	c. Quarters	d. Other (*Specify*)
	NA		

22. Signature of Supervisor	23. Title and Office Phone Number	24. Date (*Mo., day, year*)
Robert C. O'Neill	Supervisor, Mail & Delivery 703/860-2480	1/10/83

Form CA-3
Rev. Dec. 1974

Exhibit 3-4

Claim For Compensation On Account Of Occupational Disease

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, First, Middle)*: Potter, Joseph Andrew
2. Social Security Number: 220-00-1898
3. OWCP File Number *(If known)*: A25-342012
4. Is Claim Being Made For Wage Loss? [X] Yes [ ] No
5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? [ ] Yes [X] No
6. Period Compensation Is Claimed As A Result of Wage Loss *(Mo., Day, Year)*: From: 3/8/85 Through: 4/30/85
7. Has Any Pay Been Received For The Period Shown In Item 6? [ ] Yes [ ] No If Yes, State Full Amount And Inclusive Dates For Such Period *(Mo., Day, Year)*: $ _____ From: 3/8/85 Through: 4/4/85
8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? [ ] Yes [X] No If Yes, Give Name and Address Of Such Party Or Insurance Carrier
9. Status Of Third Party Claim/ Amount Of Recovery

10. Were You Ever In The Armed Forces of The United States?	A. Service Number	B. Name And Address of Office Where Claim is Filed	C. Period of Service
[ ] Yes [X] No If Yes, Furnish	NA		From: Through:

11. Have You Ever Applied For Or Received Benefits From The VA Based On Service In The Armed Forces of The United States?	A. Claim No.	B. VA Address Where Claim is Filed	C. Nature of Disability and Monthly Payment
[ ] Yes [X] No If Yes, Furnish	NA		$ _____

12. Have You Applied For or Received an Annuity Under The U.S. Civil Service or Other Federal Retirement or Disability Law?	A. Claim No.	B. Date Annuity Began *(Mo., Day, Year)*	C. Amount of Monthly Payment
[ ] Yes [X] No If Yes, Furnish	NA		$ _____

13. List Your Dependents *(If none so state)*

Name	Relationship	Date Of Birth	Is Dependent Living With You? Yes	No	If Not, Show Mailing Address
JOAN M.	wife	2/4/42	✓		
DENNIS R.	son	8/12/70	✓		

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

NA

15. I certify, under the penalty of law, that the disease or illness described above was a result of my employment with the United States Government and that it was not caused by my willfull misconduct, intent to injure myself or any other person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which s/he person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

Joseph A. Potter — Your Signature or Signature of Person Acting For You

4/7/85 — Date *(Mo., Day, Year)*

Exhibit 3-5

Form CA-4
(Rev. Sept. 1984)

STATEMENT OF OFFICIAL SUPERIOR

16. Name and Mailing Address of Reporting Office *(Name, Number, Street, City, State, Zip Code)*
U.S. POSTAL SERVICE
N. CAPITAL & MASS. Ave. NW Wash DC 20013

17. Date and Hour Pay Stopped *(Mo., Day, Year)*
4/5/85 ☒ AM ☐ PM

18. Pay Rate At Time Employee Stopped Work

	Base Pay	Subsistence	Quarters
Amount $ 18,750 Per year	$ Per	$ Per	$ Per
	$ Per	$ Per	$ Per
	$ Per	$ Per	$ Per

19. If Employee Receives Other Additional Pay, Such As Premium, Sunday, or Night Differential Identify Type and Show Amount.
Type NA $ Per

20. Show Workweek At Time Pay Stopped If Other Than Monday Through Friday.
S (M T W T F) S

21. Show Inclusive Dates Employee Received Pay For Any Part of The Periods Shown in Block 4 On The Front Of This Form

Annual Leave:		Sick Leave:		Other:	
From 3/8/85	To 3/25/85	From 3/28/85	To 4/4/85	From 4/5/85	To 4/30/85

22. Did The Employee Work In The Position A Full Eleven Months Prior To Stopping Work Due To The Illness Or Disease?
☒ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Afforded Employment For Eleven Months Except For The Disease Or Illness?
☐ Yes ☐ No NA

24. Deductions

	Health Benefits	Optional Life Insurance
A. Was Employee Enrolled On Date Pay Stopped?	☒ Yes No ☐	☐ Yes No ☒
B. If Yes, Furnish Code Number.	3 1 2	
C. If Yes, Give Month, Day, Year, Through Which Deductions Were Made.	( )	( )

25. *(Check One)*
☒ Employee Has Not Returned To Work
☐ Employee Has Returned To Work *(If this box is checked complete items 26 through 29)*

26. Date and Hour Returned To Work *(Mo., Day, Year)*
Has Not ☐ AM ☐ PM

27. Show Employee's Workweek On Return To Duty If Other Than Monday Through Friday
S M T W T F S

28. Show Employee's Rate Of Pay On Return To Duty

Base Pay	Subsistence	Quarters	Other
$ Per	$ Per	$ Per	$ Per

29. Did The Results Of The Disability Require A Change In The Employee's Work Assignment On Return To Duty?
☐ Yes ☐ No If Yes, Complete A
Unknown

A. Describe Type Of Work Employee Is Now Performing

30. I hereby certify that the information given above and furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions *(A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.)*:

31. Signature Of Official Superior	32. Title	33. Date *(Mo., Day, Year)*
Fred Jones	Supervisor Mails	4/10/85

Exhibit 3-5

READEX FICHE

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

1. NAME OF DECEASED EMPLOYEE (Last, first, middle)	2. DATE OF BIRTH (Mo., day, year)	3. DATE OF INJURY (Mo., day, year)	4. DATE OF DEATH (Mo., day, year)	5. SOCIAL SECURITY NUMBER
GOODMAN, ARTHUR ALLEN	8-24-22	2-12-80	2-13-80	422-00-1123

6. NAME AND ADDRESS OF EMPLOYING AGENCY (Include Zip Code): U.S. Postal Service, 1211 Main Street, New York City, NY 10028

7. NATURE OF INJURY WHICH CAUSED DEATH: Vehicle Accident

CLAIM OF SURVIVING HUSBAND OR WIFE (Items 8 through 13)

8. NAME AND ADDRESS (Include Zip Code): ALICE GOODMAN, 674 CANAL ROAD, New York City, NY 10014

9. YOUR DATE OF BIRTH (Mo., day, year): 11-24-25

10. DATE OF MARRIAGE TO EMPLOYEE (Mo., day, year): 6-13-44

11. WERE YOU LIVING WITH THE EMPLOYEE AT TIME OF DEATH? [X] YES [ ] NO

12. WERE YOU EVER MARRIED TO ANYONE OTHER THAN THE EMPLOYEE? [ ] YES [X] NO

13. WAS EMPLOYEE EVER MARRIED TO ANYONE OTHER THAN YOURSELF? [ ] YES [X] NO

14. LIST ALL OF EMPLOYEE'S CHILDREN FROM THIS MARRIAGE WHO MAY BE ENTITLED TO COMPENSATION (See attached information sheet for definition of children):

NAME	RELATIONSHIP	DATE OF BIRTH	ADDRESS (Include Zip Code)
Jane Goodman	daughter	4-8-46	Same as above
Anthony Goodman	son	5-12-48	Same as above

14a. LIST ALL OF EMPLOYEE'S CHILDREN FROM PRIOR MARRIAGES WHO MAY BE ENTITLED TO COMPENSATION:

NAME	RELATIONSHIP	DATE OF BIRTH	ADDRESS (Include Zip Code)
NA			

15. IF A LEGAL GUARDIAN HAS BEEN APPOINTED FOR ANY CHILD NAMED ABOVE, GIVE NAME OF CHILD, NAME AND ADDRESS OF THE GUARDIAN.

CHILD	GUARDIAN	GUARDIAN'S ADDRESS (Include Zip Code)
NA		

16. LIST OTHER RELATIVES WHO WERE FULLY OR PARTIALLY DEPENDENT ON EMPLOYEE:

NAME	RELATIONSHIP	DATE OF BIRTH	ADDRESS (Include Zip Code)
NA			

17. IF EMPLOYEE WAS EVER IN THE ARMED FORCES OF THE UNITED STATES, GIVE:
SERVICE NUMBER: NA
BRANCH OF SERVICE:
PERIOD OF SERVICE:

18. IF APPLICATION HAS BEEN MADE FOR VETERANS ADMINISTRATION (VA) BENEFITS BECAUSE OF EMPLOYEE'S DEATH, GIVE:
VA CLAIM NUMBER:
ADDRESS OF VA OFFICE WHERE CLAIM IS FILED: NA

19. IF APPLICATION HAS BEEN MADE FOR U.S. CIVIL SERVICE ANNUITY BECAUSE OF EMPLOYEE'S DEATH, GIVE:
CSF CLAIM NUMBER: NA
DATE ANNUITY BEGAN:
AMOUNT PAID PER MONTH: $

20. IF CLAIM HAS BEEN MADE AGAINST A THIRD PARTY BECAUSE OF EMPLOYEE'S DEATH, GIVE: not yet settled
AMOUNT OF RECOVERY: $
NAME AND ADDRESS OF THIRD PARTY: Gregory Parks, 820 44th Ave, Flushing, NY 11241

21. TOTAL BURIAL EXPENSE	22. AMOUNT OF BURIAL EXPENSE PAID OR PAYABLE BY VA	23. NAME AND ADDRESS OF PARTY (Other than VA) WHOSE FUNDS WERE USED TO PAY BURIAL EXPENSE AND AMOUNT PAID
$ 6500.00	$ NA	$ 6500.00 Alice Goodman (Same as above)

I HEREBY CERTIFY THAT EACH AND EVERY STATEMENT MADE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

24. SIGNATURE OF PERSON FILING CLAIM	25. ADDRESS (Include Zip Code)	26. DATE (Mo., day, year)
Jane Goodman	674 Canal Road NYC, NY 10014	2/26/80

Form CA-5
REV. NOV. 1974

Exhibit 3-6

ATTENDING PHYSICIAN'S REPORT

1. NAME OF DECEASED EMPLOYEE *(Last, first, middle)*	2. DATE OF DEATH *(Mo., day, year)*

3. WHAT HISTORY OF INJURY OR EMPLOYMENT RELATED DISEASE WAS GIVEN TO YOU?	4. IF TREATED FOR DISEASE, GIVE DIAGNOSIS.

5. IF DEATH WAS NOT INSTANTANEOUS, DESCRIBE THE TREATMENT YOU PROVIDED.	6. SHOW DATES ON WHICH TREATMENT WAS GIVEN.

7. WHAT WAS THE DIRECT CAUSE OF DEATH?

8. WHAT WERE THE CONTRIBUTORY CAUSES OF DEATH, IF ANY?

9. IN YOUR OPINION, WAS THE DEATH OF THE EMPLOYEE DUE TO THE INJURY AS REPORTED IN ITEM 3 ABOVE? ☐ YES ☐ NO GIVE THE MEDICAL REASONS FOR YOUR OPINION, UNLESS CAUSAL RELATIONSHIP IS OBVIOUS.

10. WAS A BIOPSY OR AN AUTOPSY PERFORMED? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS OF PHYSICIAN AND ARRANGE FOR A COPY OF THE REPORT TO BE SUBMITTED.

11. NAME AND ADDRESS *(Please type - include Zip Code)*	12. SIGNATURE	13. DATE SIGNED *(Mo., day, year)*

U.S. GOVERNMENT PRINTING OFFICE: 1976 - 653 748/153

Exhibit 3-6

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

CLAIM FOR COMPENSATION BY PARENTS, BROTHERS, SISTERS, GRANDPARENTS, OR GRANDCHILDREN

1. NAME OF DECEASED EMPLOYEE (Last, first, middle)	2. DATE OF BIRTH (Mo., day, year)	3. DATE OF INJURY (Mo., day, year)	4. DATE OF DEATH (Mo., day, year)	5. SOCIAL SECURITY NUMBER
Mayer, George Allen	1-18-47	3-4-83	3-4-83	580-40-2947

6. NAME AND ADDRESS OF EMPLOYING AGENCY (Include zip code)	7. NATURE OF INJURY WHICH CAUSED DEATH
U.S. Postal Service 2411 Broadway Cincinnati, OH 05234	Internal Bleeding caused by Vehicle accident

8. NAME OF DEPENDENT (Last, first, middle)	9. DEPENDENT'S ADDRESS (Include zip code)	10. DEPENDENT'S BIRTH DATE (Mo., day, year)
Alice Mayer	212 Gooseberry Lane Cincinnati, OH 05341	4-6-20

11. DEPENDENT'S OCCUPATION	12. DEPENDENT'S SOCIAL SECURITY NUMBER	13. DEPENDENT'S RELATIONSHIP TO EMPLOYEE	14. EXTENT OF DEPENDENCY ON EMPLOYEE
NA	279-48-3111	Mother	☒ TOTAL ☐ PARTIAL

15. TOTAL AMOUNT EMPLOYEE CONTRIBUTED TO DEPENDENT'S SUPPORT DURING 12 MONTHS IMMEDIATELY PRIOR TO DEATH	16. DID EMPLOYEE LIVE WITH DEPENDENT DURING THE 12 MONTHS IMMEDIATELY PRIOR TO DEATH?	17. TOTAL AMOUNT EMPLOYEE PAID DEPENDENT IN MONEY OR SERVICE FOR ROOM AND BOARD IN ADDITION TO AMOUNT SHOWN IN 15.	18. IF NO FIXED AMOUNT WAS PAID FOR ROOM AND BOARD, WHAT IS THE FAIR VALUE OF SUCH ROOM AND BOARD?
$ 4800.00	☒ YES ☐ NO IF "YES," COMPLETE 17 & 18.	$ NA PER	$ NA PER

19. IF DEPENDENT WAS EMPLOYED DURING 12 MONTH PERIOD PRIOR TO EMPLOYEE'S DEATH, GIVE:	20. SHOW DEPENDENT'S INCOME FROM ALL SOURCES OTHER THAN EMPLOYMENT DURING 12 MONTH PERIOD PRIOR TO EMPLOYEE'S DEATH:
TYPE OF WORK PERFORMED PERIOD OF EMPLOYMENT: NA MONTHLY PAY RATE NAME AND ADDRESS OF EMPLOYER	INVESTMENTS $ NA PENSIONS PERSONS OTHER THAN EMPLOYEE OTHER TOTAL $

INFORMATION ABOUT DEPENDENT'S HUSBAND OR WIFE (Items 21 through 25)	21. BIRTH DATE (Mo., day, year)	22. OCCUPATION	23. MONTHLY PAY RATE	24. TOTAL INCOME FROM ALL SOURCES FOR 12 MONTHS PRIOR TO EMPLOYEE'S DEATH
	5-10-48	NURSE	$800.00	$9600.00

25. LIST ALL PROPERTY OWNED BY DEPENDENT AND HUSBAND OR WIFE (omit clothing, furniture, personal items) GIVE DESCRIPTION, DATE ACQUIRED AND APPROXIMATE VALUE OF EACH.

DESCRIPTION	DATE ACQUIRED	VALUE
Split-level house	1963	$68,000

26. IF EMPLOYEE WAS EVER IN THE ARMED FORCES OF THE UNITED STATES, GIVE:	27. IF AN APPLICATION HAS BEEN MADE FOR VETERANS ADMINISTRATION (VA) BENEFITS BECAUSE OF EMPLOYEE'S DEATH, GIVE:
SERVICE NUMBER BRANCH OF SERVICE: NA PERIOD OF SERVICE:	VA CLAIM NUMBER: NA ADDRESS OF VA OFFICE WHERE CLAIM IS FILED:

28. IF AN APPLICATION HAS BEEN MADE FOR U.S. CIVIL SERVICE ANNUITY BECAUSE OF EMPLOYEE'S DEATH, GIVE:	29. IF A CLAIM HAS BEEN MADE AGAINST A THIRD PARTY BECAUSE OF EMPLOYEE'S DEATH, GIVE:
CSF CLAIM NUMBER: DATE ANNUITY BEGAN: NA AMOUNT PAID PER MONTH: $	AMOUNT OF RECOVERY: $115,000 NAME AND ADDRESS OF THIRD PARTY: George Crush 642 Astor Rd. Cincinnati, OH 05342

30. TOTAL BURIAL EXPENSE	31. AMOUNT OF BURIAL EXPENSE PAID OR PAYABLE BY VA	32. NAME AND ADDRESS OF PARTY (OTHER THAN VA) WHOSE FUNDS WERE USED TO PAY BURIAL EXPENSE AND AMOUNT PAID:
$ 6900	$ NA	George Crush 642 Astor Rd. Cincinnati, OH 05342 $ 6900

I hereby certify that each and every statement made above is true to the best of my knowledge.

33. SIGNATURE OF PERSON FILING CLAIM	34. ADDRESS (Include Zip code)	35. DATE (Mo., day, year)
Alice Mayer	Same as item #9	3/24/83

GPO 812-313

Form CA-5b
Rev. Sept. 1975

Exhibit 3-7

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

OFFICIAL SUPERIOR'S REPORT OF EMPLOYEE'S DEATH

1. Name of Deceased Employee (Last, first, middle): GREEN, LARRY A.	2. Date of Birth (Mo., day, year): 3/21/30	3. ☒ Male ☐ Female	4. Social Security No.: 703-49-0000
5. Department or Agency: U.S. Postal Service	6. Bureau or Office: Mangrove, MT 87401		
7. Name and Address of Reporting Office: Main Post Office, Mangrove, MT 87401 — Zeke Zook, Injury Compensat. Spr.	8. Name and Office Phone Number of Employee's Official Superior: Clyde Kramer 791/999-7911		
9. Date and Hour of Injury (Mo., day, year): 4/6/72 2 AM ☐ PM ☒	10. Date and Hour of Death: 4/6/72 315 AM ☐ PM ☐	11. Date and Hour Employee's Pay Stopped (Mo., day, year): 4/7/72 730 AM ☒ PM ☐	
12. Describe How Injury Occurred: CARRIER GREEN WAS STRUCK BY A CAR	13. Was Employee in Performance of Duty When Injury Occurred? ☒ Yes ☐ No (If No, Explain):		
14. Location Where Injury Occurred: Corner of First & OAK STREETS	15. Location Where Death Occurred: DOA at Mangrove Hospital	16. Immediate Cause of Death (Attach Medical and Autopsy Reports if Available): Multiple Trauma	

17. Employee's Pay Rate As Of	a. Base Pay	b. Subsistence	c. Quarters	d. Other
A. Date of Injury $22,000	$ per	$ per	$ per	$ per
B. Date Pay Stopped	$ per	$ per	$ per	$ per

18. Did Employee Work in Position Held At Time of Injury for a Full Eleven Months Immediately Prior to the Injury? ☒ Yes ☐ No

19. If Answer to 18 is No, Would Position Have Afforded Employment for Eleven Months Except for the Injury? ☐ Yes ☐ No

20. Did Employee Receive Leave Pay for Any Part of Period from Time Pay Stopped to Date of Death? (Give Inclusive Dates)

a. Annual NA b. Sick NA c. Other (Specify) NA

21. Did Employee Receive Continuation of Pay (COP) During Period Prior to Death? NA

a. Pay Rate Used For COP	b. Inclusive Dates of COP	c. Gross Dollar Amount of COP
$ per	From To	$

22. If Employee was Enrolled in Health Benefit Plan for Self and Family, Show HBS Code Number:	23. Show Date Through Which HBS Deductions Were Last Made (Mo., day, year)	24. If Employee Received Medical Care Prior to Death, Give Name and Address of Attending Physician
3/2		NA

25. If Injury was Caused by a Third Party Give Name and Address of Third Party	26. Give Name and Address of the Attorney Representing the Survivors if Legal Action is Instituted Against the Third Party	27. Show Amount of Third Party Recovery, If Any
Dan Guzzler, 21 Bourbon Street, Mangrove, MT 87401	BILL BARNEY, 2 LEGAL WAY, MANGROVE, MT 87401	$

28. If Employee was a Member of the Armed Services of the United States, Show:	29. Has a Claim for Survivor's Benefit Been Filed with the United States Civil Service Commission?
Branch of Service: ARMY Serial No. (if known) RA 11201702	☐ Yes ☒ No

30. Name and Address of Employee's Spouse or Next of Kin (Show relationship, if other than spouse)
INA MAE GREEN, 143 N HILL STREET, MANGROVE, MT 87401

31. Signature of Official Superior	32. Title	33. Date (Mo., day, yr.)
Clyde Kramer	POSTMASTER	4/16/72

Form CA-6
Rev. July 1975

Exhibit 3-8

Claim For Compensation On Account Of Traumatic Injury

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*: Marshall, Brandon NMI
2. Social Security Number: 225-00-1780
3. OWCP File Number *(If known)*: A10-893216
4. Is Claim Being Made For Wage Loss? ☒ Yes ☐ No
5. Is Claim Being Made For Schedule Award Based On Permanent Disability Involving Member, Organ Or Function Of Body? ☐ Yes ☒ No
6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*. If Pay Loss Was Intermittent, Attach Separate Sheet Showing Dates And Hours Of Pay Loss. From: 3/31/82 Through: 4/15/82
7. Has Any Pay Been Received For The Period Shown In Item 6? ☒ Yes ☐ No If Yes, State Full Amount And Inclusive Dates For Such Periods *(Mo., day, yr.)* $ _____ From: 3/31/82 Through: 4/10/82
8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☒ No If Yes, Give Name And Address Of Such Party Or Insurance Carrier
9. Status Of Third Party Claim/ Amount Of Recovery: NA
10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☒ No If Yes, Furnish → a. Service Number: NA; b. Branch Of Service; c. Period Of Service *(Mo., day, year)* From: _____ Through: _____
11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? ☐ Yes ☒ No If Yes, Furnish → a. Claim Number: NA; b. Address Of VA Office Where Claim Is Filed; c. Nature of Disability And Monthly Payment
12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☒ No If Yes, Furnish → a. Claim Number: NA; b. Date Annuity Began *(Mo., day, year)*; c. Amount of Monthly Payment $ _____
13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
NA				

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation under the Federal Employees' Compensation Act, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

15. Employee's Signature	16. Employee's Home Mailing Address *(Include Zip Code)*	17. Date *(Mo., day, year)*
Brandon Marshall	603 Briarwood Ave Memphis, TN 38116	4/18/82

Form CA-7
June 1984

Exhibit 3-9

EL-505, TL-3, 10-31-85

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office (Number, street, city, state, Zip Code)
Injury Compensation Unit, U.S. Postal Service, 511 Main Street, Memphis, TN 38170, Attn: Alice Markwood

19. Pay Rate As Of:

	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury	$ 12,200 per yr	$ per	$ per	$ per
Date Employee Stopped Work	$ 12,200 per yr	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e., Premium, Sunday, Night Differential, Identify Type And Show Amount
Type ____ $ NA per ____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
$ (M) T W T F $

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?
☒ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?
☐ Yes ☐ No NA

24. Total Length of Employee's Federal Civilian Service
5 yrs

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other (Specify) LWOP
4/8/82 - 4/10/82	3/31/82 - 4/7/82	4/11/82 - 4/15/82

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$ 12,200 per yr

27. Inclusive Dates Regular Pay Continued During Period of Disability. Do Not Include Periods of Sick or Annual Leave
From: 2/14/82 Through: 3/30/82

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$ 1,542.95

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate (Mo., day, year)
NA

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
$ ____ per ____	$ ____ per ____	$ ____ per ____	$ ____ per ____

PART D – COMPENSATION

30. Date And Hour All Pay Terminated (Mo., day, yr.)
Pay Not Terminated ☐ AM ☐ PM

31. Period For Which Compensation Is Claimed
From: 3/31/82 Through: 4/15/82

32. Deductions:
a. Was Employee Enrolled On Date Pay Stopped? Health Benefits ☒ Yes ☐ No; Optional Insurance ☐ Yes ☒ No
b. If Yes, Furnish Code Number. Health Benefits: 3 0 1; Optional Insurance: ☐☐☐
c. If Yes, Give Date Through Which Deductions Were Made Last.

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work (Mo., day, year)
4/16/82 8:30 ☒ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ 12,200 per yr

35. Show Work Week On Return To Work If Other Than Monday Through Friday
$ (M) T W T F $

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.
NA

PART F – CERTIFICATION

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date (Mo., day, year)
William Barker	Tour Superintendent 649-8033	4/20/82

Form CA-7
Rev. June 1984

Exhibit 3-9

Claim For Continuing Compensation
On Account Of Disability

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

STATEMENT OF INJURED EMPLOYEE – SEE INSTRUCTIONS ON REVERSE SIDE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*: O'KEEFE, DAVID Albert

2. OWCP FILE NUMBER, IF KNOWN: A 30 - 406210

3. HOME MAILING ADDRESS *(Include ZIP code)*: 200 MALIBU DRIVE, SILVER SPRING, MD 20901

4. SOCIAL SECURITY NUMBER: 333-00-8810

5. DATE AND HOUR OF INJURY *(Mo., day, year)*: 5/12/80 — 1130 ☒ AM ☐ PM

6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)* IF PAY LOSS WAS INTERMITTENT ATTACH SEPARATE SHEET SHOWING DATES AND HOURS OF PAY LOSS. FROM: 11/5/81 THROUGH: 11/30/81

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6? ☐ YES ☒ NO SHOW INCLUSIVE DATES. FROM: THROUGH:
IF LEAVE USE WAS INTERMITTENT, ATTACH SEPARATE SHEET SHOWING DATES AND HOURS USED.

8. DO YOU WISH TO REPURCHASE LEAVE? ☐ YES ☒ NO

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6. ATTACH A SEPARATE SHEET IF NEEDED.

a. SALARIED EMPLOYMENT.

DATES & HOURS WORKED	PAY RATE *(Per hour, day or week)*	TOTAL AMOUNT EARNED	TYPE WORK PERFORMED	NAME & ADDRESS OF EMPLOYER
NA				

b. COMMISSION AND SELF-EMPLOYMENT. *SHOW ALL ACTIVITIES, WHETHER OR NOT INCOME RESULTED FROM YOUR EFFORTS.*

DATES & HOURS WORKED	NAME AND ADDRESS OF BUSINESS	SELF-EMPLOYED ☐ COMMISSION ☐	TYPE OF ACTIVITY PERFORMED	INCOME DERIVED (ATTACH EXPLANATION IF NEEDED)
NA				

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION NO.	DATE OF REGISTRATION	OFFICE ADDRESS
NA		

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.
NA

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO.	NATURE OF DISABILITY AND MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
NA		

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO.	AMOUNT OF MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
NA		

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF. Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.
David A. O'Keefe

15. DATE *(Mo., day, year)*: 11/30/81

Exhibit 3-10

Form CA-8
Revised April 1984

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)*
HAS NOT ☐ AM ☐ PM

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY

S	M	T	W	T	F	S

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6 ON THE REVERSE SIDE?
☐ YES ☒ NO

19. IF ANSWER TO ITEM 18 IS YES, SHOW:
AMOUNT: $
TYPE OF PAYMENT: NA
PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(I.e. change of plan or option; If additional deductions have been made by the agency, show amount and period.)*

NA

21. REMARKS
Employee has been referred to an orthopedic specialist to determine fitness for duty.

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(mo., day, year)*
Ken Roberts	Supervisor, Mails	11/30/81

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1 through 15 on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16 through 24 and forward the form to the appropriate OWCP office.

b. The official superior must also complete items 1 through 6 on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3 on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: FAILURE TO SUBMIT THIS FORM PROPERLY COMPLETED WITH SUPPORTING MEDICAL EVIDENCE WILL DELAY PAYMENT OF COMPENSATION.

Exhibit 3-10

Authorization For Examination And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No.: 1215-0103
Expires: 09/30/86

The following request for information is authorized by law (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

PART A – AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

Dr. Frederick K Snyder
Calvin Coolidge Hospital
Staunton, VA 24401

2. Employee's Name (Last, first, middle)	3. Date of Injury (Mo., day, yr.)	4. Occupation
Parker, John Edward	12/19/82	Distribution Clerk

5. Description of Injury or Disease:

Pain in lower back while lifting a tray of mail

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☒ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be due to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)	8. Signature of Authorizing Official: Mark Fisher
NA	9. Name and Title of Authorizing Official: (Type or print clearly) Mark Fisher Inj. Comp. Supervisor
10. Local Employing Agency Telephone Number: (703) 860-1245	11. Date (Mo., day, year) 12/19/82

12. Send one copy of your report: (Fill in remainder of address)

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs
3535 Market St
Rm 15100
Philadelphia, PA
19104

13. Name and Address of Employee's Place of Employment

Department or Agency: Injury Compensation U.S. Postal Service
Bureau or Office: 1430 N. Augusta St. Attn: Mark Fisher
Local Address (including Zip Code): Staunton, VA 24401

Form CA-16
(Rev. 6/84)

OMB No. 1215-0155
Expires: 09/30/86

Duty Status Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

This request for information is authorized by law (5 USC 8101 et seq.). Benefits and/or medical expenses may not be paid or may be subject to suspension under the Federal Employees' Compensation Program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS FORM

SUPERVISOR: Complete Part A and refer the form to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. To prevent interruption of the employee's pay, the completed form should be returned to the employing agency *(as shown in Item 12)* within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP *(as shown in Item 11)*.

PART A – SUPERVISOR

1. Name and Address of Medical Facility Providing Medical Services

2. OWCP File Number *(If known)*

3. Employee's Name *(Last, first, middle)*

4. Date of Injury *(Month, day, yr.)*

5. Social Security No.

6. Occupation

7. Describe How the Injury Occurred and State Parts of the Body Affected.

8. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying: Sedentary 0—10 lbs.			Hrs Per Day	p. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying: Light 10—20 lbs.			Hrs Per Day	q. Reaching above Shoulder			Hrs Per Day
c. Lifting/Carrying: Moderate 20—50 lbs.			Hrs Per Day	r. Heat			degrees F
d. Lifting/Carrying: Heavy 50—100 lbs.			Hrs Per Day	s. Cold			degrees F
e. Sitting			Hrs Per Day	t. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	u. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	v. Fumes (Identify)			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	w. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	x. Noise			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	y. Other (Describe)			Hrs Per Day
k. Bending			Hrs Per Day	9. Does the Job Require Driving a Vehicle? ☐ Yes (Specify _____) ☐ No Operating Machinery? ☐ Yes (Specify _____) ☐ No			
l. Stooping			Hrs Per Day				
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day	10. The Employee Works _____ Hours Per Day _____ Days Per Week			
o. Simple Grasping			Hrs Per Day				

11. Send A Copy of This Report To:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

12. Send The Original Report to *(Name and Address of Employing Agency)*:

Form CA-17
Rev. August 1985

Exhibit 3-12

PART B – PHYSICIAN

13a. Does the History of Injury Given to You by the Employee Correspond to That Shown in Item 7?
☐ Yes ☐ No *(If not, describe)*

13b. Description of Clinical Findings

13c. Diagnosis of Condition Due to Injury

13d. Diagnosis of Other Disabling Conditions

14. Is Employee Able to Perform His/Her Regular Work *(Described on the Front of This Form)*?
☐ Yes, If so, ☐ Full-Time or ☐ Part-Time _____ Hours Per Day
(Fill In)
☐ No, If not, complete Item 15 below.

15. Complete the Following If the Answer To Item 14 is "No".

Activity/Exposure	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying: Sedentary 0—10 lbs.			Hrs Per Day	p. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying: Light 10—20 lbs.			Hrs Per Day	q. Reaching Above Shoulder			Hrs Per Day
c. Lifting/Carrying: Moderate 20—50 lbs.			Hrs Per Day	r. Heat			degrees F
d. Lifting/Carrying: Heavy 50—100 lbs.			Hrs Per Day	s. Cold			degrees F
e. Sitting			Hrs Per Day	t. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	u. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	v. Fumes (Identify)			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	w. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	x. Noise			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	y. Are Interpersonal Relations Affected Because of A Neuropsychiatric Condition? *(e.g., Ability to Give or Take Supervision, Meet Deadlines, etc.)* ☐ Yes *(Describe)* ☐ No			
k. Bending			Hrs Per Day				
l. Stooping			Hrs Per Day				
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day				
o. Simple Grasping			Hrs Per Day				

16. Describe Any Other Function of This Employee's Regular Work Which is Medically Restricted By The Injury.

17. Period of Disability *(If termination date is unknown, so state)*
Total Disability From To
Partial Disability From To

18. If Employee is Able to Resume Work, Has He/She Been Advised?
☐ Yes ☐ No
If Yes, Give Date of Advice _____

19. Date of Examination

20. Date of Next Appointment, If Scheduled

I certify that all statements made above are true. I further understand that any knowingly false or misleading statement, or concealment or misrepresentation of material fact may subject me to felony criminal prosecution.

21. Typed or Printed Name and Address of Physician

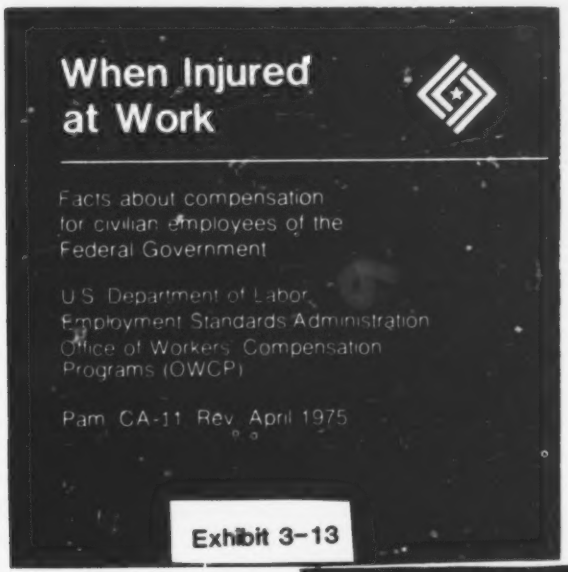
22. Specialty

23. Tax Identification Number

24. Physician's Signature

25. Date

Exhibit 3-12



When Injured at Work

Facts about compensation for civilian employees of the Federal Government

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

Pam. CA-11 Rev. April 1975

Exhibit 3-13

NOTICE TO EMPLOYEE

The attached card provides instructions for you and your family in the event of your injury or death as a result of your employment.

Detach the card and keep it in your wallet for reference. It is important that you and your dependents know what to do in order to receive FECA benefits.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)
Washington, D.C. 20211

WORK INJURY BENEFITS FOR FEDERAL EMPLOYEES

If you sustain injury, which includes occupational disease, damage to medical braces, artificial limbs, or other prosthetic devices, you may be entitled to benefits of the Federal Employees' Compensation Act (FECA).

WHEN INJURED

1. Notify your supervisor immediately and obtain authorization for medical care.
2. In traumatic injuries, you or someone acting on your behalf must complete the employee's portion of Form CA-1 and return it to your employing agency within 2* working days after the injury. Use Form CA-2, instead of Form CA-1, if disability results from an occupational disease. For more detailed information, carefully read the "Benefits . . ." and "Instructions . . ." sheets which are attached to the Forms CA-1 and CA-2.
3. If disabled due to traumatic injury, you may use leave, or request continuation of pay, not to exceed 45 days. Thereafter compensation is claimed on Form CA-7. If disabled due to occupational disease, you may use leave, or claim compensation on Form CA-4.

*(Claim may be valid if filed within 3 years following the injury.) (over)

Form CA-13
Rev. Feb. 1975

DEATH BENEFITS

Compensation may also be payable to certain members of your family for job-related death. A claim for death benefits must be filed with your agency or the OWCP no later than 3 years following death. Beneficiaries may obtain assistance from your agency or the OWCP.

For additional information about the FECA, read pamphlet CA-11, When Injured at Work, (Rev. 4/75), available from your agency. The agency will also give you all needed forms and the address of the OWCP office which services your area.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)
Washington, D.C. 20211

INSTRUCTIONS TO FEDERAL AGENCIES

1. Issue this card to each employee of your agency.
2. Further information regarding the Federal Employees' Compensation Act (FECA) may be obtained from the OWCP and/or Chapter 810 of the U.S. Civil Service Commission's Federal Personnel Manual.
3. Additional cards may be obtained from the OWCP office servicing your area.

Form CA-13
Rev. Feb. 1975

Exhibit 3-14

MASTER LOG
FOR
INJURY COMPENSATION ACTIVITY

AP/YR	NAME LAST, FIRST, MI	SSN	PL	DOI	TYPE OF CLAIM	NATURE OF INJURY	COP START	COP END	CONTROVERT YES	CONTROVERT NO	CLAIM NO.	REMARKS

Exhibit 3-15

MASTER LOG
FOR ASSOCIATE OFFICE
INJURY COMPENSATION ACTIVITY

AP/YR	NAME LAST, FIRST, MI	SSN	PL	DOI	TYPE OF CLAIM CA-1, CA-2, CA-2A, etc.	NATURE OF INJURY Sprained Back, Dog Bite, etc.	COP START	COP END	CONTROVERT YES	CONTROVERT NO	CLAIM NO.	REMARKS

Exhibit 3-16

CLAIM CONTROL REGISTER

☐ Traumatic ☐ Ill/Disease ☐ Third Party ☐ Controverted

Employee's Name _____ SSN _____ DOB _____

Address _____ Telephone _____ PL _____

OWCP No. _____ DOI _____ Nature of Injury _____

Physician's Name, Address and Phone _____

Date Stopped Work _____

Date COP Began _____

Date Pay Stopped _____

AL/SL _____

Date Returned to Duty _____

Recurrences

Date	Date Stopped Work	Returned to Duty

Date Forms Sent to OWCP		
CA -	Date	Remarks
CA -		
CA -		

COP TRACKING SHEET

DAY	DATE	COMMENTS	DAY	DATE	COMMENTS
1			24		
2			25		
3			26		
4			27		
5			28		
6			29		
7			30		
8			31		
9			32		
10			33		
11			34		
12			35		
13			36		
14			37		
15			38		
16			39		
17			40		
18			41		
19			42		
20			43		
21			44		
22			45		
23					

COMPENSATION

From _____ To _____

LIMITED DUTY

From _____ To _____

REMARKS

CONTROVERSION LOG

AP/YR	NAME LAST, FIRST, MI	SSN	PL	DOI	TYPE OF INJURY	DATE OF CONTROVERSION	PAY TERMINATED YES	PAY TERMINATED NO	CLAIM NO.	CWCP RULING AND DATE	REMARKS

Exhibit 3-18

Exhibit 3-19

THIRD PARTY REGISTER
A/P _____ FY _____

Col # 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
NAME	SSN	DOI	2562 (x)	OWCP CASE (x)	COP & OWCP RECOVERY BY OWCP	ATTY & EMPL CASE (x)	COP & OWCP RECOVERY BY ATTY & EMPL	ASSN CASE (x)	COP & OWCP RECOVERY BY USPS	GROSS AMT COL 10	CLSED AFSO TO PURS (x)	CLSED NO COLL (x)	COP HOURS RECOVRD	COP FUNDS RECOVRD

REHABILITATION LOG

A/P	NAME LAST, FIRST, MI	OWCP CLAIM NO.	DATE OF OWCP REFERRAL	JOB OFFER MADE	DATE Accepted	DATE Declined	OPM SELECTION	MANAGEMENT Refusal	REMARKS

Exhibit 3-20

U.S DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

OWCP Number	
Injured Worker	
Payment - 28 days	
Payment - Lifetime	

OWCP has found that rehabilitation through reemployment can reduce the cost of compensation and is the preference of the injured worker. This worker is receiving the above amount in compensation payments from you every 28 days. You could be benefiting from this person's productivity. If reemployment cannot be achieved, we estimate your compensation cost may be the above amount over the lifetime of this individual.

The work restriction evaluation form from the physician indicates there are many work activities this worker can perform. With proper placement this employee can perform work equal to that of any non-disabled employee. A disability does not have to be a vocational handicap.

I can assist you in your effort to reemploy this person. If needed, I can provide a vocational evaluation to identify the worker's abilities, or training for developing new skills or placement assistance for appropriate work assignments to ensure the employee's successful return to work. I will be counseling with this person to assist in any readjustment problems. Please call me about this individual at the above number.

Enclosed is the Work Restriction Evaluation and the recent medical report for your official and confidential use.

Sincerely,

Division of Vocational Rehabilitation

Enclosures

Copy distribution: WHITE - Employer
CANARY - Injured Worker
PINK - OWCP Rehab. File
GOLDENROD - OWCP Case File

Include your address, ZIP code, and file number on all correspondence

Ltr. OWCP-8
Rev. Aug. 1980

U.S. Postal Service

INJURY COMPENSATION DATA COLLECTION

▶ Read Instructions on Reverse		A/P	FY	MSC No.
To: Regional Injury Compensation Program Administrator	From		FTS Telephone No.	Date Submitted

Claims Experience	CA-1	10.	Program Reviews	AO's	51.
	CA-2	11.		MSC's	52.
	CA-2a	12.	Inspection Service	Claims Referred	53.
	CA-4	13.		Referrals Terminated	54.
	CA-6	14.		Jacketed	55.
	CA-7	15.		Rejected	56.
Rehab/Reemployment	OWCP Referrals	26.	Controversions	Total Submitted	60.
	Referrals Terminated	27.		Controversions Terminated	61.
	Official Mgmt Refusals	28.		Upheld Decisions	62.
	Job Offers	29.		Denied Decisions	63.
	Accepting Offer	30.		COP Hours Avoided	64.
	Selecting OPM/CSC	31.		COP Cost Avoided	65.
	Declining Offer	32.	Third Party Claims	Total Forms 2562	70.
	Comp Cost Reduction	33.		OWCP Claims	71.
USPS Initiated Reemployments	Returned to Work	35.		No. Recovered	72.
	Declined Job Offer	36.		Amt Govt Recovery	73.
	Selected OPM/CSC	37.		Empl/Att Claims	74.
	Reassignment	38.		No. Recovered	75.
	Comp Cost Reduction	39.		Amt Govt Recovery	76.
FFD Exams Initiated	Concurring	40.		USPS Assignments	77.
	Non-Concurring	41.		No. Recovered	78.
Separations	To OWCP	43.		Amt Govt Recovery	79.
	Pending OWCP	44.		Amt Gross Recovery	80.
Limited Duty	Employees Fit For L.D.	45.		Refusal to Pursue	81.
	Actually Assigned L.D.	46.		Collection Terminated	82.
Inj. Comp. Training	Receiving USPS Training	48.		COP Hours Recovered	83.
	Receiving OWCP Training	49.		COP Funds Recovered	84.

Prepared By	Printed Name & Title	Signature
Reviewing Official	Printed Name & Title	Signature

PS Form 2572 June 1984

Exhibit 3-21

GENERAL

All items are for activity in current A/P.

Data submitted will be consolidated with other source data (COP and Charge-Back Printouts), calculated and totaled by the Region (ELRIC). The final product (a single consolidated printout) will be provided on an A/P basis to MSC/BMC and District for verification and analytical purposes. District Managers will also receive a summary report.
NOTE: It is imperative that you submit accurate and verifiable data. The printout report and calculated FYTD figures can only be as reliable as your submitted data.

PREPARATION: By ICS or person responsible for managing injury claims. Installation head or highest available authority signs as "Reviewing Official" before submitting to RICPA. Typewriter completion required. Any dollar amount must be rounded off. Do not enter dollar signs ($) or commas(,).

TIME LIMIT: Submit not later than 5 days after close of each A/P. Forms received later will not be included in that A/P report, but treated as adjustment and included in next report in FYTD.

ADJUSTMENTS: Corrections will be accomplished by submitting a separate Form 2572-A, "Update Worksheet", each A/P along with your Form 2572.

SPECIFIC

CLAIMS EXPERIENCE

10-15. All claims (active or inactive, lost time or no lost time, numbered or unnumbered) which were alleged and/or filed by means of listed forms.
16. Reserved for Printout as "Total".

COP DATA

17-24. Reserved for Printout (data extracted and/or calculated by ELRIC).

REHAB–REEMPLOYMENT

25. Reserved.
26. Disabled former or current (on LWOP/IOD) employees who are officially referred to USPS by OWCP for reemployment in accordance with the Joint Rehab Program. Do not include reemployed current employees for which you did not receive an OWCP referral.
27. Referrals previously reported in Item 26 for which no management refusal or job offer will be made. Example: Medical condition again becomes unstable.
28-32. All entries in 31 must also be reported in 29 for correct "Pending Rehab Cases".
33. Amount ($) of compensation benefits (received by disabled employees) which have been terminated or reduced due to the Joint Rehab Program. Compute on basis of normal life expectancy of age 70. Multiply expected remaining years of each candidate times annual rate or reduction in compensation rate. Add 6% to total for OWCP's administrative cost.

    Do not prorate annual reduction in compensation on an A/P basis and carry the figure for a separate number of years for each individual. The full cost reduction on each candidate should be recognized and reflected in the A/P that the action took place. Do not include expected benefits for employees who were returned to employment due to full recovery, since a full recovery, in itself, would nullify further compensation payments.
34. Reserve for Printout as "Pending Rehabilitation Cases".

USPS INITIATED REEMPLOYMENT

35-37. Former or current (on LWOP/IOD) employees reemployed or reassigned without an OWCF referral.
35. No. actually returned to work.
36. No. declined the job offer.
37. No selected OPM/CSC.
38. Current employees (working limited duty) permanently reassigned due to a permanent partial disability for which medical accommodations have been made.
39. Comp Cost Reduction. Compute same as Item 33.

FITNESS FOR DUTY EXAMINATIONS INITIATED

40. Concurring–examination findings which agree with those of the private/treating physician.
41. Non-concurring–exam findings which differed from those of the private/treating physician. There should be no split decisions. If our FFD exam did not clearly or significantly oppose the findings of the private physician, it should be reflected as a "concurring" exam.
42. Reserved for Printout as "Total Exams Conducted".

SEPARATIONS

43. Employees separated to OWCP payment rolls.
44. Employees separated with option to select OWCP payments in lieu of OPM annuity.

LIMITED DUTY

45. Employees with job related injuries who were initially declared fit for limited duty by means of a medical report from Physician of Record (Form CA-17 or other) received during current A/P. Do Not include those found fit in previous A/P's.
46. Employees of item 45 initially assigned limited duty (LDC-68) during current A/P. Do not include employees assigned limited duty code (68) during previous A/P's who continued to work limited duty during current A/P.
47. Extra field.

INJURY COMPENSATION TRAINING

48. Personnel in your office or area who were provided with USPS training on Injury Compensation.
49. Personnel in your office or area who received OWCP training on Injury Compensation.
50. Extra field.

PROGRAM REVIEWS (AUDITS)

51. Reviews conducted at associate offices within your area.
52. Management Section Centers reviewed by reporting ICS or within your area.

INSPECTION SERVICE

53. Questionable and/or fraudulent claims submitted for professional investigative assistance.
54. Referrals previously reported in Item 53 which will not be jacketed or rejected. Example: New evidence received.
55. Accepted (jacketed) as worthy of pursuit.
56. Rejected–lacking sufficient grounds to warrant further investigation.
57. Reserved for printout as "Pending Inspection Service".

CONTROVERSIONS

60. Controversions submitted to OWCP during current A/P.
61. Controversions previously reported in Item 60 which will not be upheld or denied. Example: Controverted in error.
62. Decisions received during current A/P that were *in favor of USPS*.
63. Decisions received during current A/P that were *in favor of claimant*.
64-65. The main purpose of these items is to provide some indication of the value of successful controversions. Reflect COP hours and funds avoided, saved, or prevented through successful controversions. Take credit for and list all COP hours and funds that were prevented during that particular A/P, even if the employee lost time and claimed COP but the COP hours were pending until receipt of OWCP decision.
66. Reserved for Printout as "Pending Controversion Decisions".

THIRD PARTY CLAIMS

70. Number of actual claims that a Form 2562, Injury Compensation Program–Notice of Potential Third Party, was completed on.
71. Claims not covered under agreement, (or employee refusals to pursue) which are forwarded to OWCP for collection.
72. Number of recoveries by OWCP.
73. Amt. total reimbursement to government. (USPS and OWCP)
74. Claims covered under the agreement that employee or attorney will pursue.
75. Number of recoveries by empl/attorney.
76. Amt. total reimbursement to government. (USPS and OWCP)
77. Claims covered under the agreement assigned to USPS.
78. Number of recoveries by assignment.
79. Amt. total reimbursement to government (USPS and OWCP)
80. Amount of gross recovery by assignment. Include government recovery, employee share, surplus, etc.
81. Number claims employee refused to pursue. For statistical purposes only, has no impact on Pending "3rd Party Cases," Item 88. These claims should also be reported in Item 71 if forwarded to OWCP for collection.
82. Number of claims previously reported in Items 71, 74, or 77 above that collection is terminated because it is not in the best interest of the Postal Service to continue collection action. This item is necessary for correct computation of Item 88, "Pending 3rd Party Cases."
83-84. COP hours and funds recovered, all categories. Report in A/P in which recovery was effected or when notice was first received.
85. Reserved for Printout as "Total New Claims".
86. Reserved for Printout as "Number Total Recoveries".
87. Reserved for Printout as "Total Government Recovery".
88. Reserved for Printout as "Pending 3rd Party Cases".

NET CONTINUATION OF PAY

90. Reserved for Printout as "Net COP Hours" (line 18 minus line 83.)
91. Reserved for Printout as "Net COP Costs" (line 19 minus line 84).

NOTE: All "Pending" items will be automatically "rolled-over" or carried forward at year's end and reflected on the printout received.

PS Form 2572, June 1984 *(Reverse)*

* U.S.G.P.O. 1984 -421-635/12559

U.S. Postal Service

INJURY CLAIMS ANALYSIS—UPDATE WORKSHEET

1. Updates for A/P	2. Post Office		3. Finance No.		4. FTS Telephone No.	
Item No.	Description		Adjusting A/P Value	After Change, Values Should Indicate		Automatically Updates Item(s)
				A/P	FYTD	
a	b		c	d	e	f
9	CA-1	9				15
10	CA-2	10				15
11	CA-2a	11				15
12	CA-4	12				15
13	CA-6	13				15
14	CA-7	14				15
25	OWCP Referrals	25				31
25a	Referrals Terminated	25a				31
26	Official Mgmt Refusals	26				31
27	Job Offers	27				31
28	Accepting Offer	28				
29	Selecting OPM/CSC	29				
30	Declining Offer	30				
32	Comp. Cost Reduction	32				
33	Returned To Work	33				
34	Defined Job Offer	34				
35	Selected OPM/CSC	35				
36	Reassignment	36				
37	Comp. Cost Reduction	37				
38	Concurring	38				40
39	Non-Concurring	39				40
42	To OWCP	42				
43	Pending OWCP	43				
45	Employees Fit for L.D.	45				
46	Actually Assigned L.D.	46				
48	Receiving USPS Training	48				
49	Receiving OWCP Training	49				
51	AO's	51				
52	MSC's	52				
56	Claims Referred	56				
56a	Referrals Terminated	56a				59
57	Jacketed	57				59
58	Rejected	58				59
61	Total Submitted	61				64
61a	Controversions Terminated	61a				64
62	Upheld Decisions	62				64
63	Denied Decisions	63				64
65	Cop Hours Avoided	65				
66	Cop Cost Avoided	66				
67	Total Claims *(Form 2562)*	67				
68	OWCP Claims	68				73
68a	No. Recovered	68a				73
68b	Amt Government Recovery	68b				
69	Empl/Att Claims	69				73
69a	No. Recovered	69a				73
69b	Amt Government Recovery	69b				
70	USPS Assignments	70				73
70a	No. Recovered	70a				73
70b	Amt Government Recovery	70b				
70c	Amt Gross Recovery	70c				
71	Refusal to Pursue	71				
72	Collection Terminated	72				73
74	Cop Hours Recovered	74				
75	Cop Funds Recovered	75				
Contact's Name				FTS Telephone No.		

PS Form **2572A**, Oct. 1983

Exhibit 3-22

USPS 7A104520
PHC340P1
REG EASTERN
DIS
MSC
P.O. NAME 10-000

U.S. POSTAL SERVICE WORKERS COMPENSATION
QUARTER 01 1983
BY FINANCE NUMBER

EXHIBIT 3-23

PAGE 10,554
DATE 11/03/82

NAME/SSN	DOI	CASE NO.	INJURY N L E	PAY PER	MEDICAL	DAILY	PERIODIC	FATAL	RECOVERED	TOTAL	PD-TO-DATE
LORD 200-70-2000	11/81	xxxxxxxxx	09 11 X	CP	80	0	0	0	0	80	
				YTD	80	0	0	0	0	80	80
VINCENT 800-00-0000	02/82	xxxxxxxxx	05 17 1	CP	31	0	0	0	0	31	
				YTD	31	0	0	0	0	31	31
FORDHAM 500-00-0000	04/74		00 99 X	CP	0	0	9,429	0	0	9,429	
				YTD	0	0	9,429	0	0	9,429	272,478
ENDER 245-20-8800	10/77	xxxxxxxxx	07 12 1	CP	50	0	2,664	0	0	2,714	
				YTD	50	0	2,664	0	0	2,714	71,886
HEART 282-00-5555	03/31	xxxxxxxxx	09 11 X	CP	4,000	0	0	0	0	4,000	
				YTD	4,000	0	0	0	0	4,000	8,093

FINANCE NUMBER TOTAL	CURRENT PERIOD	YEAR-TO-DATE	PAID-TO-DATE
MEDICAL PAYMENTS	$ 4,469	$ 4,469	
DAILY COMPENSATION	$ 0	$ 0	
PERIODIC COMPENSATION	$ 22,944	$ 22,944	
FATAL PAYMENTS	$ 0	$ 0	
RECOVERIES	$ 0	$ 0	
TOTAL	$ 27,413	$ 27,413	$ 622,662

MSC TOTAL			
MEDICAL PAYMENTS	$ 4,469	$ 4,469	
DAILY COMPENSATION	$ 0	$ 0	
PERIODIC COMPENSATION	$ 22,944	$ 22,944	
FATAL PAYMENTS	$ 0	$ 0	
RECOVERIES	$ 0	$ 0	
TOTAL	$ 27,413	$ 27,413	$ 622,662

Exhibit 3-24

WORKERS COMPENSATION-INJURY ON DUTY AP-11 FY-82

AAR072P2
REGIONAL POSTMASTER G 1
XXXXX DISTRICT 1E
Anytown State 015

MSC SUMMARY

	••COP HRS USED••• CUR PER	SPLY	% CHG	••COP HRS USED••• PER 100 EMPL CUR PER	SPLY	% CHG	••• COP COSTS •••• CUR PER	SPLY	% CHG	••LWOP/IOD HRS •• CUR PER	SPLY	% CHG	•NO OF EMPL• ON COP CU PD	SPLY	% CHG	•NO OF EMPL• LWOP/IOD CU PD	SPLY	% CHG
MSC Name				797									8	11	27-	8	12	33-
TOTAL NO OF EMPLOYEES				43	99	56-	3655	8414	56-	1064	1436	26-	56	99	43-	20	24	16-
CP 344	809	57-		674	1264	46-	54075	100310	46-	9693	12645	23-						
YD 5378	10296	47-											43	73	41-			
AVG COP HR USE PER EMPL YEAR-TO-DATE													96	104	7-			
Associate Office Name Fin. No. 29																1	1	
TOTAL NO OF EMPLOYEES				300	2826	89-	866	8215	89-	120	160	25-	2	4	50-	2	1	100
CP										1176	760	54						
YD 87	848	89-																
AVG COP HR USE PER EMPL YEAR-TO-DATE													43	212	79-			
Associate Office Name Fin. No. 22																		
TOTAL NO OF EMPLOYEES				250	1047	76-	606	2451	75-	40			1	2	50-	1		
CP																		
YD 55	241	77-																
AVG COP HR USE PER EMPL YEAR-TO-DATE													55	120	54-			
Associate Office Name Fin. No. 9																1		
TOTAL NO OF EMPLOYEES										40								
CP																		
YD																		
AVG COP HR USE PER EMPL YEAR-TO-DATE																		
Associate Office Name Fin. No. 6																		
TOTAL NO OF EMPLOYEES				200			118						1					
CP																		
YD 12																		
AVG COP HR USE PER EMPL YEAR-TO-DATE													12					

AAN072P1 WORKERS COMPENSATION-INJURY ON DUTY AP-05 FY-83 PAGE 568

WASHINGTON DC 6
DISTRICT 6J 6J
000
SAN BRUNO PDC 05 9902

EMPLOYEE NAME	SSN	D/A	••••••••••COP-CURRENT PERIOD•••••••••• HRS	AMT	**RELEVANT ADJUST** HRS RPP-Y	AMT	****COP-YTD**** HRS	AMT	***CURRENT PERIOD*** OWCP LWOP HRS	ADJ HRS RPP-Y	LWOP/IOD YTD HOURS
[redacted]	[redacted]	11-9	32	556			32	556			
[redacted]	[redacted]	11-9	24	216	24 25 82	216	183	1,655	30		190
[redacted]	[redacted]	11-9					3	30			
TOTAL POST OFFICE			56	772	24	216	218	2,241	30		190

**** COP HRS & AMT INCLUDE ALL ADJ HOURS AND DOLLARS ****

EXHIBIT 3-25

EMPLOYEE RELATIONS DEPARTMENT
EMER INFORMATION SYSTEMS DIVISION
I.R.I.S.
INFORMATION RETRIEVAL AND INQUIRY SYSTEM

USPS REHABILITATION PROGRAM
DETAILED REPORT
AS OF ACCOUNTING PERIOD 6 YEAR 13-82

REGION: Central
DISTRICT: xx
MSC:
FINANCE: xxxxxxxxx

NAME	S.S.N.	ENTER ON DUTY	DES / ACT	NOA	REMARK CODE	EFF. DATE	OCC. CODE	HANDICAP CODE	RSC	LEVEL / STEP	SALARY
DOE J.	xxxxxxxxx	09/02/61	11/0	002	545	09/04/82	231504xx	49	P	05/12	$24,471
DOE J.	xxxxxxxxx	09/02/61	11/0	161	545	06/26/82	231504xx	49	P	05/12	$22,492

Exhibit 3-25

EMPLOYEE RELATIONS DEPARTMENT
E&LR INFORMATION SYSTEMS DIVISION
I.R.I.S.
INFORMATION RETRIEVAL AND INQUIRY SYSTEM

CUMULATIVE TOTAL REEMPLOYED THROUGH
USPS REHABILITATION PROGRAM
HSC SUMMARY
AS OF ACCOUNTING PERIOD 13-82

REGION: Central
DISTRICT: xx
HSC: 000

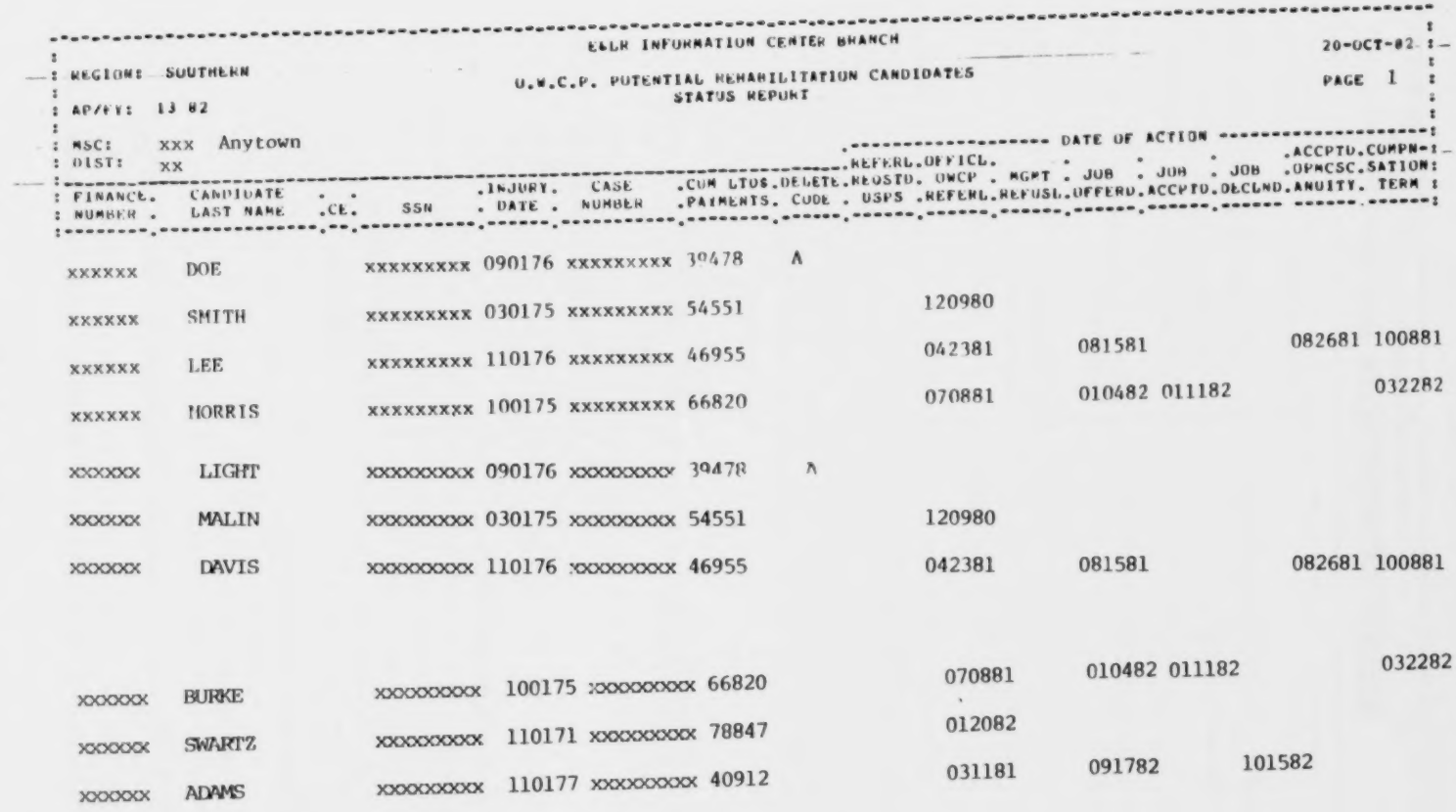
CATEGORY

POST OFFICE	MANAGEMENT	SUPERVISORS	CLERKS	MAIL HANDLERS	CARRIERS	VEHICLE SERVICES	MAINTENANCE SERVICES	SUBSEQUENTLY SEPARATED	TOTALS
FORMER EMPLOYEES									
FIN. NO. CITY, ST		1	12	1		1			15
SUB TOTAL		1	12	1		1			15

CATEGORY

POST OFFICE	MANAGEMENT	SUPERVISORS	CLERKS	MAIL HANDLERS	CARRIERS	VEHICLE SERVICES	MAINTENANCE SERVICES	SUBSEQUENTLY SEPARATED	TOTALS
CURRENT EMPLOYEES									
FIN. NO. CITY, ST			3				1		4
SUB TOTAL			3				1		4
TOTAL		1	15	1		1	1		19

Exhibit 3-25



E&LR INFORMATION CENTER BRANCH — 20-OCT-82

REGION: SOUTHERN

U.W.C.P. POTENTIAL REHABILITATION CANDIDATES STATUS REPORT — PAGE 1

AP/FY: 13 82

MSC: xxx Anytown

DIST: xx

FINANCE NUMBER	CANDIDATE LAST NAME	CE	SSN	INJURY DATE	CASE NUMBER	CUM LTDS PAYMENTS	DELETE CODE	DATE OF ACTION: REFERL USPS	OFFICL REQSTD	OWCP REFERL	MGMT REFUSL	JOB OFFERD	JOB ACCPTD	JOB DECLND	ACCPTD OPNCSC	COMPN ANUITY	TERM
xxxxxx	DOE		xxxxxxxxx	090176	xxxxxxxxx	39478	A										
xxxxxx	SMITH		xxxxxxxxx	030175	xxxxxxxxx	54551			120980								
xxxxxx	LEE		xxxxxxxxx	110176	xxxxxxxxx	46955			042381		081581			082681		100881	
xxxxxx	MORRIS		xxxxxxxxx	100175	xxxxxxxxx	66820			070881		010482	011182					032282
xxxxxx	LIGHT		xxxxxxxxx	090176	xxxxxxxxx	39478	A										
xxxxxx	MALIN		xxxxxxxxx	030175	xxxxxxxxx	54551			120980								
xxxxxx	DAVIS		xxxxxxxxx	110176	xxxxxxxxx	46955			042381		081581			082681		100881	
xxxxxx	BURKE		xxxxxxxxx	100175	xxxxxxxxx	66820			070881		010482	011182					032282
xxxxxx	SWARTZ		xxxxxxxxx	110171	xxxxxxxxx	78847			012082								
xxxxxx	ADAMS		xxxxxxxxx	110177	xxxxxxxxx	40912			031181		091782		101582				

Exhibit 3-26

EL-505, TL-3, 10-31-85

Exhibit 3-26

U.S. Postal Service

REQUEST—OWCP CLAIM STATUS

OWCP File No.

Section A.

To:

Office of Workers Compensation Programs

U.S. Department of Labor

_____

_____

Instructions

A. Postmaster: Enter File No. and complete Sec. A. Check request boxes in Sec. B. as needed (1-5). Forward to OWCP District Office in duplicate.

B. OWCP Office: The employee below has filed a claim with you. Please help us determine this claimant's status by completing Sec. B as checked (1-5). Sign, date, and return copy to Requester.

Requester

Name: _____

Address: _____

_____

Date: _____

Claimant

Name: _____

Work Address: _____

_____

Date Injured: _____

Section B.

This information is confidential and is used only for official Postal Service purposes.

1. ☐ Claim for Benefits is:
   - ☐ a. Accepted (Date) _____
   - ☐ b. Rejected (Date) _____
   - ☐ c. Pending

2. ☐ Employee is Currently Receiving Compensation:
   - ☐ a. Yes (Complete Item 3.)
   - ☐ b. No

3. ☐ Type/Amount of Payment:
   - ☐ a. Temporary Total Disability of $_____ per _____.
   - ☐ b. Permanent Total Disability of $_____ per _____.
   - ☐ c. Loss of Wage Earning Capacity of $_____ per _____.
   - ☐ d. Scheduled Award of $_____ per _____.

   Terminates (Date) _____

4. ☐ Last Medical Examination (Date): _____ (Attach Copy)

5. ☐ Other *(Specify)*: _____

_____

_____

Signature & Title (OWCP Officer)	Date

PS Form 2573 June 1982

Chapter 4
Timekeeping and Accounting Procedures

410 Purpose

To ensure that injury compensation costs are held to a minimum, accurate input of time and attendance is necessary. The purpose of this chapter is to provide the control office/point with specific guidelines for the proper handling of timekeeping and accounting procedures.

420 Compensation Procedures

421 Input and recovery of continuation of pay.

421.1 Definition

Employees who suffer disabling, job-related traumatic injuries are entitled to continuation of pay (COP) for the length of their disability, up to a maximum of 45 calendar days. (See Subchapter 540 in the ELM)

421.2 Use of COP

The 45 calendar days begin either:

(a) The start of the employee's first full tour after the injury is sustained, or

(b) The first calendar day following the injury, or

(c) The day or shift (other than the day of injury) during which the employee stops work (including initial work stoppage) for only a portion of the day or shift. Such a day or shift will be counted as one calendar (full) day for purposes of totaling the 45 days, whichever occurs first. "Any absence during that day or shift beyond the time needed to obtain the physical therapy (or initial medical treatment) cannot be charged to COP." (FECA Manual 2-500.7.)
Continuation of pay can be received only if the disability begins within 6 months of the occurrence of the injury. In recurrence cases COP is allowed if:

a. The initial claim had been previously approved or is pending adjudication by OWCP.

b. The 45 calendar days were not all used during the initial period of disability.

c. The recurrence is within 6 months of the date the employee first returned to work following the initial period of disability.

421.3 COP Limitation

Employees cannot use more than 264 hours of "COP" leave for any one injury. (Exceptions: Rural carriers, J Route, cannot exceed 288 COP hours. Rural Carriers, H Route, cannot exceed 312 COP hours.) The ICS is responsible for ensuring that the maximum COP hours are not exceeded. If warranted, prompt investigation and corrective action should be taken. Exceeding the maximum of 264 hours of COP could reflect: (a) overpayment, (b) Rural Carriers with H or J routes, or (c) two or more injuries. Injury compensation personnel should share their findings with the safety staff and other managers as appropriate.

EXAMPLES:

1. An employee is called in ahead of his scheduled tour, is injured during the call-in period, and is then unable to continue to work due to the injury.

The 45 calendar day period begins at the start of the scheduled tour.

2. An employee is injured during his scheduled tour and is unable to work due to the injury.

The 45 calendar day period begins on the next calendar day.

3. An employee works only a portion of a day or tour (other than the day or tour when the injury occurred) and is then unable to continue to work due to the injury.

That day or tour is counted as one calendar day toward the 45-day period.

422 COP Applicability

Continuation of pay applies only to employees who are suffering traumatic injuries. Persons disabled as a result of occupational illnesses (those illnesses which are the result of continued exposure to a condition of the work environment) do not receive COP; they are eligible for injury compensation benefits from the Office of Workers' Compensation Programs,

U.S. Department of Labor (OWCP), under the Federal Employees' Compensation Act, or sick leave or annual leave, as appropriate.

423 Authorization and Supporting Forms

423.1 Form 3971, *Request for, or Notification of, Absence,* which authorizes "COP Leave" must not be filed until a Form CA-1, *Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation,* is submitted. Until the CA-1 is filed, the employee must have his time charged to sick/annual leave or LWOP. After the CA-1 is filed, the control office/point will ensure initiation of an adjustment form, if necessary, to correct the leave entries. The procedures for completing an adjustment form in this situation are described in Chapter 7 of F-21 and F-22.

423.2 The time lost must be certified by a physician as being a result of the job-related condition. The medical certification must address the employee's capability to perform regular duty or limited duty.

423.3 Promptly upon being advised that an employee has claimed continuation of pay, a supervisor must ensure that Form 3971 is completed. COP should not be entered for pay purposes unless there is a Form CA-1 on file.

423.4 When an employee is directed by management to a medical unit (either on or off site) due to illness or injury, all time spent waiting for and/or receiving medical attention on the service day on which the illness or injury occurred -- and which would otherwise have been worked -- is credited as work time. (F-21, 146.27, F-22, 393.33)

423.5 If an employee is excused from work because of a disabling, job-related, traumatic injury that occurred during the employee's scheduled tour, the remaining portion of the tour is to be charged to Other Paid Administrative Leave, rather than Continuation of Pay.

423.6 On the day that the employee leaves the work area due to a disabling traumatic, job-related injury, the employee is to be paid for the entire regular tour that he was scheduled to work. The timekeeper must subtract the total number of hours worked during the day from the total number of hours scheduled to be worked. The balance is charged as administrative leave.

U.S. Department of Labor (OWCP), under the Federal Employees' Compensation Act, or sick leave or annual leave, as appropriate.

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423.6 On the day that the employee leaves the work area due to a disabling traumatic, job-related injury, the employee is to be paid for the entire regular tour that he was scheduled to work. The timekeeper must subtract the total number of hours worked during the day from the total number of hours scheduled to be worked. The balance is charged as administrative leave.

423.7 a. A regular schedule employee (full-time or part-time) receives continuation of pay for the number of hours (excluding overtime) he would have worked if he had not been injured.

b. A part-time flexible schedule employee receives continuation of pay in an amount equal to the average weekly number of paid hours that the employee had during the previous 52 weeks (excluding overtime).

c. A casual or temporary employee, or other intermittent employee, (e.g., substitute rural carrier, auxilliary rural carrier, rural carrier relief, etc.) who is not part of the regular work force, receives continuation of pay in an amount equal to the average weekly number of paid hours he had during the previous 52 weeks, (excluding overtime). However, in no case may the continuation of pay for a full week be less than 24 hours.

d. A part-time flexible schedule, casual temporary or other intermittent employee (e.g., substitute rural carriers, auxilliary rural carriers, rural carrier relief) who has not worked one full year, receives continuation of pay in an amount equal to the average weekly number of paid hours that he had during the most recent period of appointment (excluding overtime) (rather than the average over the previous 52 weeks).

424 SPECIAL INSTRUCTIONS

424.1 Minimum COP Benefits

Employees with irregular and intermittent service, e.g., substitute rural carriers, casual employees, auxiliary rural carriers, are eligible for a minimum of 24 hours per week of COP. This minimum does not apply to either the week COP begins or the week it ends.

424.2 Premium Benefits

Employees who normally would have been eligible to receive Sunday premium or night shift differential will continue to receive these premiums while in "COP status."

424.3 Holidays Within COP

Employees normally entitled to pay for holidays will have any holiday falling within the 45 calendar day period recorded as holiday pay but counted as part of the COP.

424.4 "Proximity Rule" - Rural Carriers

.41 It is the OWCP's position that rural carriers who provide their own transportation to deliver mail are covered by the FECA while driving to and from work. Therefore, if a rural carrier suffers a disabling traumatic injury prior to the scheduled reporting time, the 45 calendar days would begin on the date of the injury (the first full tour after the injury is received.)

.42 The ICS should controvert any CA-1 filed under the "Proximity Rule" if the rural carrier is using the vehicle as a privately owned vehicle while driving to and from work under Item 6d, "the injury occurred off the employing agency's premises and the employee was not involved in official "off premises" duties," e.g., deviating from normal route of travel for shopping, transporting a passenger, etc. Postal regulations prohibit a rural carrier from carrying unauthorized persons in the vehicle while on duty or employing a driver or helper without the approval of management.

424.5 Election Changed within 45-Day Period

An election of sick or annual leave during the 45-day period is not irrevocable. An employee who first elected sick or annual leave may change his election to COP; the agency must honor such a request on a prospective basis, i.e., effective from the date of the employee's written request. However, the agency is not required to restore leave and substitute COP retroactively. Nevertheless, if an employee requests, such retroactive action may be taken at the discretion of the installation head.

425 First Aid Examination and Treatment for On-the-Job Injury or Illnesses

425.1 Employee on Regular Tour

If an employee on regular tour of duty is injured or becomes ill and the injury or illness can be treated so that the employee can return to duty during that tour, the employee is excused without charge to annual or sick leave. The employee is not required to clock out when leaving the place of duty for first-aid examination or treatment. If the employee is unable to return to duty as a result of the injury/illness, the control office/point must contact the immediate supervisor. (See ELM 519.6)

425.2 Employee in Overtime Status

When an employee is directed by management to a medical unit (either on or off site) due to illness or injury, all time spent waiting for and/or receiving medical attention on the service day on which the illness or injury occurs -- that would otherwise have been worked -- is credited as work time. The employee's timecard is so noted and initialed by the supervisor. (ELM 519.6). This does not imply that an employee whose treatment extends beyond his scheduled end of tour is to be credited for that time. An employee will be credited only for the number of hours he was scheduled to work that day.

427 COP Entries-EAS Employees

427.1 Instructions for recording the leave hours of FLSA-exempt EAS employees is contained in Management Instruction EL-430-80-3, dated June 28, 1980. To comply with Department of Labor regulations, these instructions are amended to provide that Continuation of Pay (COP) may be granted to an FLSA-exempt EAS employee in less than full-day increments when, following an injury on duty, the employee returns to work on a part-time basis due to medical limitations or when time off from work is required for treatment of the injury. In such instances, however, COP may be recorded only in combination with work hours (including personal absence), court leave, military leave, and administrative leave equal to a full service day of 8 hours. It cannot be combined with annual leave, sick leave, LWOP or AWOL.

427.2 When an exempt EAS employee is granted personal absence for some or all of the balance of a full service day of 8 hours in which COP is taken, the personal absence time is recorded as workhours. Installation heads should contact their regional Compensation Division for special instructions when an exempt EAS employee desires to work on a limited basis over an extended period while recuperating from an illness or disability.

427.3 For bargaining-unit and FLSA nonexempt EAS employees, COP may be recorded in any combination with work hours and all types of leave to equal a full service day.

428 Continuation of Pay Beyond Separation

428.1 General

The Federal Employees' Compensation Act provides that an employee who suffers a traumatic job-related injury prior to separation will be separated from the service as scheduled, but will be entitled to Continuation of Pay (COP) for up to 45 calendar days. Payment may be terminated before the completion of 45 days if:

a. The postal installation receives medical information from the attending physician to the effect that the former employee is no longer disabled, or

b. The postal installation receives notification from the Office of Workers' Compensation to terminate pay. The responsible employees at the postal installation must carefully monitor the Injury on Duty (IOD) cases to insure that COP is not paid beyond the last day authorized or the 45th day, whichever comes first. Although the COP may extend beyond the date of separation, the administrative policies stated in the Employee & Labor Relations Manual (ELM) 540, are applicable, as are the procedures in Handbook F-21, *Time and Attendance,* 392, and in Handbook F-22, *Postal Source Data System Time and Attendance,* 393.

428.2 Identification of Separated Employee in COP Status

An employee whose COP extends beyond separation will be appropriately identified via special coding requirements on the Form 50, *Notice of Personnel Action.* Personnel offices preparing a Form 50-A for a separating employee entitled to COP beyond separation must make the following entries.

ITEM NO.	ITEM NAME	CODING ENTRY
21.....	Probation Expiration Code	9
22.....	Probation Pay Period and Expiration Code PP-Yr the year 45-Day COP Expires	
23.....	Employee Status CP	95
27.....	RSC.....+W	

If after separation it is determined that the COP is to be terminated at an earlier date, issue another

Form 50-A, *Nature of Action 002, Correction,* with the appropriate pay period and year in Item 22. An employee whose wages before separation were subject to FICA, will have FICA, in addition to Federal, state and local taxes, withheld from COP after separation. Retirement deductions, optional life insurance, health benefit and leave credit, if formerly applicable, will continue to be deducted until COP is ended.

429 **COP For Disability "Beginning After" Separation**

429.1 When disability begins after separation but within 6 months after the date of injury, the employee is entitled to 45-days continuation of pay, effective retroactively from the date of disability specified by the treating physician. This date will be provided by your OWCP district office.

429.2 The law states that limited duty must be made available to the employee. Therefore, if the medical evidence indicates that the employee was fit for limited duty during the period of disability but was not offered it (because he was terminated), he would still be entitled to full compensation for this period.

429.3 The Postal Service is responsible for paying the employee a total of 45-days continuation of pay (if necessary), retroactive to the first day of disability due to the injury, regardless of whether or not the employee has terminated his employment.

429.4 For any disability which renders the employee temporarily, totally and/or partially disabled after the 45th day, he should be instructed to submit a Form CA-7, listing the dates of total and/or partial disability and medical reports to substantiate the disability.

430 **Other Compensation Issues**

431 **Recurrence**

431.1 The employee who suffers a recurrence of a job-related disability may elect to receive continuation of regular pay (if eligible) or charge the absence to sick or annual leave, or take leave without pay and file for injury compensation benefits from OWCP. Continuation of regular pay is available as an option only:

a. If the 45 calendar days were not all used during the initial period of disability, and

b. If the recurrence is within 6 months of the date that the employee first returned to work following the initial period of disability. If the recurrence occurs more than 6 months after the employee returned to work following the disability, regular pay may not be continued, even if some portion of the 45 days remains unused. In this case, the employee is entitled only to sick or annual leave or OWCP compensation.

431.2 The phrase, "first returned to work" means the first return to any work, including part-time work. Thus, the six month period starts to run the date that the employee returned to any work, including part-time work. If the employee returns to work on the date of injury, the six month period would start on the date injured. Also, the first day of COP must be taken within six months from the date of injury.

431.3 Once the employee has begun taking COP, he is entitled to a maximum of 45 days of COP. These days need not be successive. For example, an employee is injured on May 1, files a claim on May 2, and is off from work from May 1 thru May 10, returning to work on May 11. The first day of COP would be May 2. Since nine days of COP were used, the employee would still be entitled to 36 days of COP for additional time lost because of the injury if it is certified by the treating physician. The law allows the employee six months from the first full working day following the DOI to take the full 45 days. If the same employee received a follow-up medical care on May 15, the employee could claim COP entitlement for that day and successive days of time loss which the physician stated were due to the original injury. The same employee then files a CA-2a, *Recurrence of Traumatic Injury*. Since the employee's date of return to work is May 11, the last day that this employee would be eligible to begin COP would be November 12. The employee then would have to file a compensation claim for time loss. If any of the 45 COP days were remaining as of November 12, and the employee had not begun another period of disability, he would lose entitlement to them.

432 Pay Adjustments And Recovery

432.1 Overpayment-Erroneous Timekeeping Entries

The Injury Compensation Control Office/Point should initiate a request, Form 2243, to Finance Office for a payroll adjustment to recover the COP hours. Finance Office will then submit a Form 2240 to the Postal Data Center.

432.2 Overpayment Determination

In the event of an overpayment, the OWCP determines the period of absence from the job which resulted in the overpayment in the course of adjudication of the claim. The control office/point and the employee are notified of the period of disability denied by OWCP.

432.3 Upon receipt of the initial OWCP decision, you must advise the employee within 10 days that an adjustment will be made. The Finance office will initiate a Form 2240 to have the COP changed to sick, annual, or LWOP after a new Form 3971 is submitted.

432.4 The control office/point should notify the employee by letter to make a selection of S/L, A/L, or LWOP. Exhibit 4-1 is an example of this letter.

Exhibit 4-1

The Office of Workers' Compensation has advised that the medical evidence of record does not show that you were disabled for work on _____ to _____; therefore, the Office of Workers' Compensation has determined that you are not entitled to COP on these dates. The reason for this decision is as follows: Not disabled for work on September 14, 1979. You did not seek treatment on September 14, 1979, and the certification is after the fact.

You should immediately request a leave adjustment through your immediate supervisor, electing another leave change as appropriate. If you do not submit a request within 10 calendar days of the date of this letter, the Accounting Office will process an adjustment to change the continuation of pay to Leave Without Pay.

A Form 3971 is enclosed for your convenience. Indicate in the "Remarks" section that you are requesting a change to the original Form 3971.

Injury Compensation Supervisor

cc: Accounting

OWCP-File

432.5 The ICCO/CP should log and monitor all outstanding COP adjustments and LWOP/IOD hours. When the COP adjustment has been processed, an amended CA-3 should be forwarded to OWCP showing that the COP has been recovered.

433 Eligibility For LWOP/IOD-OWCP

433.1 Injured employees are eligible for LWOP/IOD only if they have exhausted COP and have applied for and are receiving OWCP compensation benefits. If this is not the case, injured employees may select another leave status, such as S/L, A/L or LWOP, and should be recorded as such.

433.2 To correct any errors in the input of LWOP/IOD or COP hours appearing on your Workers' Compensation/Injury on Duty Report, you should initiate Form 2240, *Pay, Leave, or Other Hours Adjustment Request*. The finance/accounting section will process these adjustments.

433.3 The ICCO must notify Personnel to prepare a Form 50 when LWOP is in excess of 30 days. Form 50 will be submitted to PDC and annotated under Item 30 Remarks "LWOP for the purpose of receiving Workers' Compensation under PL93-416 (ELM 514.5)." The ICCO must also notify Personnel when the employee is returning to duty and/or pay status as a Form 50 action is required for "Return To Duty".

EXAMPLES:

TO: Personnel

Employee's Name _____
SSN _____
Designation _____P.O. &
State _____

(A) SUBJECT: LWOP

Effective _____(date)_____, above named employee is to be placed in a leave without pay status for the purpose of receiving compensation due to an injury sustained while on the job. This employee is to remain in this status until he returns to work. Completed Form CA-7/4 was submitted to the OWCP District Office on ___(date)___. Last day in pay status is ___(date)___.

(B) SUBJECT: Return to Duty

On (date) you were informed that the above named employee was placed in a leave without pay status for the purpose of receiving compensation due to an injury on the job from (date), until further notice. Leave without pay for this purpose terminated on (date). First date in return to duty status will be (date). Full Time/Part Time. ------- ICS.

434 Labor Distribution Code (LDC)

434.1 Code/Operation Numbers

LDC		OPERATION
69	Rehabilitation Employee	958
68	Limited Duty	959

434.2 Limited Duty

Limited Duty is:

a. Workhours of all employees who are recovering from a job-related injury or illness and are not able to perform their regularly assigned duties; or

b. Workhours of employees who are on OWCP but are able to work part-time (less than 8 hours per day) capacity.

434.3 The work hours of former postal employees restored to postal rolls through the Joint USPS/DOL Rehabilitation Program are classified under Labor Distribution Code 69. Offices have been credited on the Rehabilitation Tracking Report for the restoration of such former employees.

434.4 Any current postal employee whose claim for workers' compensation on account of a permanent partial disability has been approved by OWCP must be considered for return to work through the Rehabilitation Program. The work hours of current employees returned to work through the Rehabilitation Program are classified under LDC 69 (same as restored employees).

Also, offices are to be credited on the Rehabilitation Tracking Report for the reassignment of each such current employee. To get restoration credit and use of LDC 69 for work hours, a current employee returning to work must be assigned to a permanent position for which a medical accommodation has been made in accordance with the physical limitations imposed by the treating physician. Employees expected to return to their regular job, but assigned temporarily to a limited duty position while eligible for COP or after COP terminates, are excluded. Labor Distribution Code 68 is used to record the work hours of these employees.

434.5 Normally, Form 50 must be processed to reassign the current employee to the new permanent position. If no Form 50 is required (e.g, the reassignment of a distribution clerk who can permanently perform part, but not all, of the normal duties of his position), a corrected Form 50 -- with "RC" placed in item 23 -- must be processed in order for the office to be credited on the Rehabilitation Tracking Report.

435 Leave Buy-Back

435.1 Under the provisions of ELM 545.7, employees are permitted to buy back leave that was used while awaiting adjudication of their case by the Office of Workers' Compensation Programs (OWCP). In cases involving a traumatic injury, the leave which an employee is buying back must have been used after the individual's entitlement to the 45-day period of COP has ended. The OWCP does not restrict the amount of leave hours an employee may buy back. However, Postal Service regulations generally do not permit bargaining unit employees to carry over into a new leave year more than 240 hours of annual leave (ELM 512.11). Thus, when an employee buys back annual leave from a previous year in an amount in excess of the applicable maximum carry-over, such excess will be automatically forfeited.

Example:

An employee accumulates 340 hours annual leave in 1980 before an on-the-job injury. The employee uses 200 hours annual leave while waiting adjudication of the case by OWCP and the remaining 140 hours are carried over into the 1981 leave year. The case is approved in March 1981 and the employee is permitted to buy-back the 200 hours. Because these 200 hours were used in 1980, they are restored as of 1980. Therefore, when combined with the 140 hour balance and

brought forward to the 1981 leave year, the maximum carry-over rule takes effect and the employee forfeits the 100 hours that are in excess of the 240 hours maximum carry-over. It should be explained to the employee that when the leave is changed to LWOP, leave credit is not earned for that period.

435.2 Postal Data Centers are responsible for reviewing the leave usage information supplied by the local installation before establishing accounts receivable. If their review shows that some of the leave used cannot be credited without creating a forfeiture situation, the buy-back request will not be processed, and the file will be returned to the employing office. That office must then advise the employee of the needed adjustment. A new date for the last day in pay status will be determined based on the adjustment, and the request will be resubmitted to the PDC for processing. These procedures insure that an employee does not buy back more annual leave than can be recredited because of the applicable annual leave carryover ceiling.

435.3 Personnel who are responsible for processing leave buy-back requests involving a traumatic injury should use the following procedures:

a. Determine the amount of leave used by the employee after the 45-day period of COP has ended.

b. Determine if any of the annual leave being bought back is from a previous leave year. If so, determine whether this annual leave, when added to the annual leave carried over by the employee during that previous leave year (if any) will exceed the employee's annual leave carryover ceiling.

c. If the amount of leave determined in 2 above exceeds the employee's annual leave carryover ceiling, the following action should be taken:

1. Determine the amount of annual leave that can be bought back without creating a forfeiture situation.

2. Caution the employee to buy back only the amount of annual leave that can be recredited and explain why.

3. Inform the employee of the maximum amount of annual leave that can be bought back while remaining within the carryover ceiling.

d. Explain to the employee that the period of absence being bought back will be changed to leave without pay (LWOP). As a result, some loss of leave may occur. For example, for every 80 hours bought back and changed to LWOP, both annual and sick leave are reduced by the amount earned in one pay period.

436 **Internal Revenue Service (IRS) Ruling Relating To "Buy Back" Leave**

436.1 Internal Revenue Ruling 79-322 applies to "Buy Back" Leave. The ruling basically states if a Federal employee receives pay for sick leave used in 1983, and "buys back" that leave in 1984, the employee must include that sick leave pay in gross income received for 1983. Since the leave was not repurchased in the same year as it was used, the employee may not amend the 1983 tax return to exclude that sick leave pay from gross income for 1983. However, if the employee elects to "buy back" the sick leave used in 1983, the amount repaid in 1984 must be shown as an itemized deduction, before it can be claimed as a loss on the 1984 tax return.

436.2 If the employee "buys back" sick leave in the same year as it was used, the amount of that sick leave pay will not be included in the gross income for that year and, therefore, no deduction is allowed.

436.3 Employees inquiring about this issue should be advised of Internal Revenue Ruling 79-322, its basic content, and referred to the Internal Revenue Service for further answers. (FECA 79-56).

440 **Limited Duty Assignments**

Limited duty is provided to an employee who has physical limitations that have been identified by a qualified, treating physician and stem from an on-the-job injury. The regulations pertaining to limited duty are covered in ELM 546.14. Basically, when an employee is provided limited duty, the work schedule, basic work week, work location, and craft may be altered.

450 **Health Benefits Refund Program (ELM 525.132)**

451 **Explanation.**

This program is designed to reimburse injured employees for an overdeduction of health benefits

premiums by the OWCP. For the first year of compensable disability, the OWCP deducts health benefits premiums at the Postal Service rate. Thereafter, the deduction is made at the standard rate applied by the Office of Personnel Management (OPM) for federal employees. The OPM premium rate is higher than the Postal Service rate. Therefore, postal employees enrolled in a health benefits plan who are in a leave without pay (LWOP) status for over 1 year and who are also receiving OWCP compensation, may be due a refund for overdeduction of health benefits premiums.

452 Eligibility for Refund.

In order to be eligible for a health benefits refund, all of the following criteria must be met for the period of compensable disability:

a. Employee must be in a LWOP/injury on duty status. Employees who are separated from the Postal Service are not eligible.

b. Employees must receive OWCP compensation payments with health benefits premiums deducted at the OPM rate.

c. A period of at least one year has elapsed since the employee was initially placed on OWCP compensation.

453 Verification of Eligibility.

The Workers' Compensation Information System Health Benefits Report will be used in the future to verify information found on the PS Form 202, *Health Benefits Refund Program Payment Authorization*. However, until this report becomes available, injury compensation personnel must review the employee's OWCP file to determine eligibility as outlined in ELM 525.132 (B).

454 Refund.

After verifying the employee's eligibility, the following steps must be taken by ICP to process the refund:

a. Initiate Form 202 on a quarterly basis. (See Exhibit 4-2) In calculating the amount of the refund to be paid, subtract the difference between the OPM health benefits premium rate and the Postal Service rate of the health benefits plan chosen by the employee.

b. Upon completion of Form 202, obtain approval of the Management Sectional Center (MSC), manager or designee.

c. Submit the refund authorization to the MSC Finance Office for payment using Account Identifier Code 587, *Fees For Service--Postal Operations*.

d. File the original Form 202 in the employee's injury compensation file. File one copy of this form in the employee's official personnel folder and send two copies to the Finance Office.

e. The Finance Office will forward the refund and one copy of Form 202 to the employee. One copy of Form 202 will be retained by the Finance Office for its records.

U.S. Postal Service

Health Benefits Refund Payment Authorization

ISTRUCTIONS

his is to authorize payment to this employee for refund due on excess withholdings on health benefits premium from the OWCP ompensation payments.

me *(Employee/Applicant)*	Social Security No.
ddress *(City, State ZIP + 4)*	MSC Name
alth Benefits Code	Finance No.
riods Covered	Amount to be Paid
(Office Use Only)	Signature of Authorizing Official
	Approval by MSC Manager or Designee

Form 202, Oct. 1984 462-861

1 – Injury Compensation

Chapter 5
Rehabilitation

(Will be published at a later date)

pages tightly bound

Chapter 6
Fraud and Abuse

610 Purpose

The purpose of this chapter is to provide injury compensation personnel with general criteria to identify suspected fraud and abuse cases for further investigation by the Inspection Service, if warranted. This chapter will also establish a uniform procedure for referring cases to the Inspection Service.

620 Objectives of Fraud and Abuse Program

621 To aid the Injury Compensation Supervisor/Specialist in reducing compensation costs resulting from fraudulent claims.

622 To assist in gathering information leading to the removal of dishonest employees from USPS employment.

630 Definitions

631 **Fraud** -- The intentional deceptive act or series of acts committed by an individual with the specific intent to cause the Postal Service and/or OWCP to grant benefits under FECA which would not normally be provided. Examples: A faked injury or concealment of fact(s) that an injury occurred off duty.

632 **Abuse** -- Excessive, extravagant, or improper use of the FECA law in a manner contrary to its legal use in order to acquire additional benefits for personal gain. Example: prolonging the length of recovery period caused by a job-related injury.

633 Although the terms, "fraud" and "abuse" are related, they are not interchangeable. Any time employees apply for or receive FECA benefits to which they are not entitled, they are abusing FECA. It might be done because the employees are ignorant of the law and its provisions or because they feel that they are genuinely entitled to those benefits. When employees deliberately apply for FECA benefits that they know they are not entitled to, they are committing fraud. The key difference between fraud and abuse is intent. Abuse is not always fraud, but fraud is always abuse.

640 Types of Fraud and Abuse

Since investigations of FECA fraud and abuse have begun, several distinct types have emerged. Some of the types are identified below but not limited to the following:

a. Concealment with intent to defraud at the time of initial employment, prior injuries, or physical impairment. This type, in most cases, is easy to prove since documentary evidence can usually be obtained.

b. Employee reports on-the-job injury when, in fact, the injury occurred off the job.

c. Employee fabricates an injury or falsifies the extent or seriousness of the real injury. In other words, a minor bump becomes a disabling condition.

d. Employee engages in outside employment while receiving compensation payments and conceals the employment.

e. Employee regularly engages in activities which are inconsistent with the alleged injury or medical restrictions.

f. Employee has a real disabling injury, but delays returning to work after recovery.

g. Employee is no longer in the Postal Service, no longer disabled, but still receives compensation and makes no effort to return to work.

650 Warning Signals For Fraud and Abuse Cases

a. There are no witnesses to the accident. If there were witnesses, consider their reliability.

b. The injury could not logically have happened as described.

c. The injury is to soft tissue. In other words, there were no broken bones, no broken skin, no swelling, or discoloration.

d. The employee has a history of leave abuse or questionable prior claims.

e. Injury is reported when disciplinary action is pending or leave of any type is denied.

f. Casual type employee claims injury at the end of a temporary employment period.

g. Injury was not reported on day of occurrence.

h. Employee is known to engage in outside activities (sports or other work) which could cause similar type injury.

i. Employee had confrontation with supervisor prior to accident.

j. The physician involved handles mulciple claims and always indicates disability.

660 **Identification**

661 All elements of the following checklist need to be considered in reviewing the claims for possible fraud and abuse.

662 If one or more of the items in Section A are checked, the case should be referred to the Inspection Service.

663 If one or more of the items in Section B are checked, consideration should be given for possible referral to the Inspection Service (IS). However, injury compensation supervisor/specialist should carefully evaluate each case on an individual basis and only refer those cases in which there is strong probable cause to believe fraud and/or abuse is present. (See Exhibit 6-1.)

670 **Procedure**

671 Using the checklist as a guide and the criteria stated in Section 660, the injury compensation office should refer all those claims which indicate possible fraud and abuse to the Inspection Service.

672 The Injury Compensation Supervisor/Specialist will send copies 1 and 2 of Optional Form 27 (two-way Memo) (see Exhibit 6-2), along with any documented evidence, to the Inspector-in-Charge. (Retain copy 3 for claim file). The Injury Compensation Supervisor/Specialist should be certain to report each case referred to the Inspection Service in item 56 of Form 2572 for the accounting period in which referred.

673 Upon receipt of Optional Form 27, the Inspection Service will determine what action to take based on the available evidence.

673.1 The Inspection Service prepares the response under "Reply Message" section and returns copy number 2 to the Injury Compensation Supervisor/Specialist.

673.2 The Injury Compensation Supervisor/Specialist should ensure that the action taken by the IS is appropriately reported in item 57 or 58 on Form 2572 for the accounting period in which the response was received.

674 If the case has been jacketed, the IS will conduct an investigation and furnish an investigative memorandum to the installation head with a courtesy copy to the Injury Compensation Office, RICPA, ER, and DOL. The information contained in the investigative memorandum will assist management in deciding the course of action to be taken.

675 In those instances where a preliminary review discloses that additional investigation would be unproductive, the IS returns the file to the Injury Compensation Office with an explanation that the case may be resubmitted if changes in the material facts occur.

676 When evidence indicates that compensation payments should be reduced or eliminated, the Injury Compensation Office will furnish DOL with a copy of the investigative memorandum with a request for necessary action.

677 The Injury Compensation Supervisor/Specialist maintains contact with the Postal Inspector who is assigned to handle injury compensation matters in the area and, at quarterly intervals, determines the status of each FECA claim under investigation by the Inspection Service.

678 In instances in which evidence is likely to be moved or destroyed, or where emergency attention is indicated, immediately contact the Injury Compensation Inspector by telephone or in person. Follow-up the contact with a written memorandum as described in Section 672.

Name
SSN
DOI
OWCP Claim No. (if Known)
Nature of Injury

Section A

1. Evidence of falsification or alteration of forms (Include copy of form).

2. Concealment of prior injuries or physical impairments at the time of hiring. Specify. _____

_____

_____

3. Incriminating witness statement or admission by claimant. Specify. _____

_____

_____

4. Physical activity inconsistent with the nature of claimed injury. Specify. _____

_____

_____

5. Concealed employment while on compensation. Specify._____

_____

_____

6. Collusion with a physician who handles multiple claims. Name and address of physician: _____

_____

_____

Exhibit 6-1

Section B

7. Claimant has a history of leave abuse or questionable prior injuries.

   Attach PS 3972 or list of prior injuries (DOI, Claim No, and Nature of Injury).

8. Injury reported in first pay period of employment. Date entered on duty: _____

_____

_____

9. Injury reported when disciplinary action is pending or leave of any type is denied. Specify. _____

_____

10. Casual employee claims injury at end of temporary employment period. Temporary appointment NTE. _____

_____

_____

11. No witness to injury. Identify place where injury occurred. _____

_____

_____

12. Alleged injury involves soft tissue damage, such as back or muscle strain. Specify. _____

_____

_____

13. Serious personal problems are evidenced. Specify. _____

_____

_____

14. Employee is known to engage in outside activities (sports, military reserve, or other employment) which could cause similar type of injury or disprove claimed injury. Specify. _____

_____

_____

15. Employee had confrontation with supervisor prior to accident. Attach supervisor statement. _____

_____

16. Injury not reported on day of occurrence. Date injury reported. _____

_____

17. Other pertinent data: _____

_____

_____

Injury Compensation Supervisor/Specialist
Date Prepared

_____

_____

Office Telephone No.

cc: IC Folder

Exhibit 6-1

UNITED STATES GOVERNMENT

2-Way Memo

INSTRUCTIONS
Use routing symbols whenever possible.
SENDER *(Originator of message)*:
Use brief, informal language.
Conserve space.
Forward original and one copy.
RECEIVER *(Replier to message)*:
Reply below the message, keep one copy, return one copy.

Subject: FECA Claim Referral
Name:
SSN:

To : Inspector-In-Charge

DATE OF MESSAGE	ROUTING SYMBOL

SIGNATURE OF ORIGINATOR

TITLE OF ORIGINATOR

FOLD — INITIAL MESSAGE — FOLD

The attached OWCP claim and allied documentation is forwarded for possible investigation by the Inspection Service. The basis for the referral is:

REPLY MESSAGE

(For Inspection Service Response.) Based upon our review and consideration of the above referral, the following determination has been made:

1) An investigation will be conducted, and if appropriate, an Investigative Memorandum will be submitted at the conclusion of the investigation.

2) No investigation will be conducted at this time. The information will be considered along with other information of its type within a central information system.

3) Further information is necessary before a determination can be made. Please furnish the following: _____.

4) Other (comment) _____.

From : Injury Compensation Supervisor
Any Town MSC

DATE OF REPLY	ROUTING SYMBOL

SIGNATURE OF REPLIER

TITLE OF REPLIER

5027-106

1. **TO BE RETAINED BY ADDRESSEE** *(Receiver)*

OPTIONAL FORM 27 (Rev. 7-77)
GSA FPMR (41 CFR) 101-11.6

Exhibit 6-2

Chapter 7
Controversions

710 Purpose

The FECA provides for the controversion of an employee's claim for continuation of pay and/or compensation where there is reason to believe that the employee is not entitled to certain benefits under the law. It is the responsibility of all postal managers to dispute any injury compensation claim or element of that claim for which there is credible evidence of fraud, abuse, honest misjudgment by the employee, or any other circumstance which constitutes doubt as to the employee's entitlement of benefits under the FECA.

720 The Controversion Package

721 General

The controversion of a claim or element of a claim will be won or lost based on the content and validity of the controversion package. Therefore, it cannot be overemphasized that this package must be prepared with the utmost care after a thorough investigation of the circumstances surrounding the claim has been made. The package should include a cover letter and documented exhibits. A copy of the entire controversion package will be maintained in the employee's claim file with the same retention period stated in Chapter 3.

722 Cover Letter

The cover letter is the most important part of the package. It is the first document the OWCP claims examiner is exposed to and summarizes the reason for controversion. The letter should be constructed to include the following elements:

a. Introduction. The introductory paragraph should contain a reference to the claimant, the nature of the claim, and a statement that the claim or identified portion of the claim is being controverted.

b. Presentation of Evidence. The body of the cover letter presents the actual evidence or reference to the evidence which supports the controversion. The body is composed of two types of information:

1. Reference to the attachments.

2. Factual informaticn not supported by attachments.

c. The Summary: All letters should be simple and tied to the FECA statute. The final paragraph(s) should contain a concise summary of the justification for the controversion and action desired of the claims examiner, i.e., the cover letter should:

1. Describe what is being controverted and why.

2. Support your position.

3. State what action is being requested.

723 Exhibits

723.1 Purpose

In most cases controversions must be supported by factual evidence presented as exhibits. The exhibits must be referred to in the cover letter and arranged in an orderly sequence.

.12 Examples of exhibits include:

a. Witness statements (positive or negative statements) Example: Someone working in the immediate vicinity of an accident but who has no knowledge of it.

b. Supervisor's statement.

c. Medical evidence.

d. Diagrams and/or maps.

e. Photographs.

f. Time and attendance records.

g. Other documents obtained by investigation.

h. Inspector's investigative reports (if available).

.13 Importance of Exhibits

Because the exhibits make up the bulk of evidence needed for controversion, their accuracy and completeness are vital. Documents refuting a claim or portion

of a claim will weigh heavily on the adjudication of the case as long as they are relevant, accurate, and objective.

730 Types of Controversions

731 Controversion of the Entire Claim

The entire claim should be controverted when there is reason to believe that the claimant is not entitled to the benefits he is claiming. These types of cases include, but are not limited to, fraudulent claims, occupational claims filed as traumatic, honest misjudgment by claimant as to job relatedness, injuries caused by willful misconduct, and injuries sustained as a result of intoxication.

732 Partial Controversion

Any portion of a claim may be controverted when there is credible evidence to substantiate that the employee is not entitled to certain benefits under the FECA, e.g., an employee sustains a dog bite to the right leg and the treating physician states that the employee is totally disabled for two (2) days, but the employee takes four (4) days off. Although it is a legitimate injury, two days of COP should be controverted unless further evidence is provided by the claimant justifying the additional time off.

733 Controversion with Termination of COP

733.1 The FECA provides that the employing agency (USPS) may, on the basis of information submitted by the employee or secured upon investigation, controvert and terminate or withhold COP if the claim falls into one of the following nine categories:

a. Disability results from an occupational disease or illness.

b. The employee is excluded by 5 USC 8101(1) B or E.

c. The employee is not a citizen or a resident of the United States or Canada.

d. The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties.

e. The injury was caused by the employee's willful misconduct, intent to bring about injury or death of

self or another person, or was proximately caused by the employee's intoxication.

f. The injury was not reported on Form CA-1 within 30 days following the injury.

g. Work stoppage first occurred six months or more following the injury.

h. The employee initially reported the injury after his employment was terminated.

i. The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, Work Study Programs, or other similar groups. There is no entitlement to COP for these individuals; however, they may be entitled to compensation.

733.2 These nine provisions are also listed in the instructions attached to the CA-1 form. An agency may terminate or withhold COP if the controversion is based on one of these provisions. It should be noted that OWCP makes the final determination and can overturn the agency's controversion of COP.

733.3 Questionable Cases

In questionable cases, the RICPA may be consulted for a decision to withhold COP pending further developments in the case, e.g., a casual employee after having received notice of termination reports an injury sustained the day before.

734 Controversion Without Termination of COP

In all other cases in which controversion is proper, COP must be allowed if applicable and applied for, unless one of the grounds listed in Item 733.1 applies. Some reasons for controverting a claim that do not allow termination of COP are:

a. Facts of injury are questionable.

b. Medical evidence does not establish causal relationship.

c. Pre-existing condition.

d. Claimant's fitness-for-duty exam conflicts with the medical report of the treating physician.

e. The employee delayed in reporting the injury (but still filed within the 30-day time limit).

f. After being refused leave, the claimant sustains a disabling injury.

g. Lack of medical evidence to substantiate claim.

h. Diagnosis not compatible with injury.

i. Claimant refused to be examined by USPS medical officer.

735 Nonconcurrence of Occupational or Recurrence Claims

735.1 Definition

The controversion of an occupational or recurrence claim is called a nonconcurrence. The FECA provides for controversion of traumatic injury but does not specifically address occupational or recurrence claims. In these cases it is the responsibility of the claimant to provide evidence that his condition is causally related to factors of employment.

735.2 Nonconcurrence Package

The nonconcurrence package is basically the same as a controversion package; however, the claimant must submit a statement with his claim and the supervisor must comment on the accuracy of the statement. This gives the supervisor an opportunity to either substantiate or refute the information given.

740 Requirements for Adjudication by the OWCP

741 A case will not be adjudicated by the OWCP if it fails to meet any of the five basic requirements listed below. Where evidence fails to establish one of the five requirements, the examiner will try to obtain clarification of significant discrepancies and any additional information necessary to reach a decision. It is the responsibility of the injury compensation control office/point to controvert the claim if any of the following basic requirements are not established.

741.1 Time

.11 A notice of traumatic injury or occupational disease claim for compensation must be filed within the time limits specified below. (These time limits apply only

to injuries and deaths that occurred on or after September 7, 1974.)

.12 5 USC 8119 provides that written notice of injury or death must be filed within 30 days after the occurrence of the injury or death.

.13 5 USC 8122 provides that an original claim for compensation for disability or death must be filed within three years after the occurrence of the injury or death. Even if the claim is not filed within three years, compensation may still be allowed if:

(a) The immediate superior had actual knowledge (including verbal notification) of the injury or death within 30 days after occurrence (the knowledge or notification must be such as to put the immediate superior reasonably on notice of an on-the-job injury or death); or

(b) Written notice of injury or death was given within 30 days as specified in 5 USC 8119.

.14 5 USC 8122 also provides that the filing of a disability claim because of injury will satisfy the time requirements for death claim based on the same injury.

.15 5 USC 8122 further provides that the failure of any individual to comply with the three year time requirement may be excused by the OWCP on the ground that notice of injury or death could not be given because of exceptional circumstances.

741.2 Civil Employee: The injured employee or decedent must be or have been an employee of the Postal Service.

741.3 Fact of Injury: The employee or decedent must have sustained an injury as defined in the FECA.

741.4 Performance of Duty: The injury or death must have resulted from an incident or circumstance occurring while the employee was performing official duties.

741.5 Causal Relationships: The disability or death must have been caused by traumatic injury or conditions of employment. The causal relationship may be either direct or by precipitation, aggravation, or acceleration of a pre-existing or underlying condition.

Controversion Without Termination of COP
(LETTERHEAD)
Controversion of Claim: Doe, John
SSN: 000-00-0000
OWCP Claim No. (if available)
DOI: 3/6/83
Office of Workers' Compensation Programs
U. S. Department of Labor, ESA
(Street address)
City, State and Zip Code

Dear Examiner:

We are forwarding the attached claim from our employee, Letter Carrier John Doe, for your review and adjudication. Circumstances surrounding his alleged right knee injury provide grounds for controversion of this claim.

On March 6, 1983, the date of the alleged injury, Carrier Doe was observed reporting for work with a noticeable limp in his right leg. (Attachment A - Statement from Supervisor). Upon returning from his route, Carrier Doe reported that he had tripped over a sprinkler head at (address), injuring his right leg. He requested medical treatment and was issued a CA-16 to see Dr. _____.

Initial diagnosis was "strain, right knee".

Upon investigation of the premises at (address) by our Safety Specialist, it was discovered that there is no sprinkler system at that address (Exhibit B - Statement of Safety Specialist). Further, investigation revealed that Carrier Doe, an avid tennis player, had been observed playing tennis at Central Park on March 5, 1983, the evening prior to the alleged injury, by Mr. _____, a fellow letter carrier (Exhibit C - Statement from Mr. _____).

Based upon our investigation and supporting documentation, we request that Mr. Doe's claim for benefits be disallowed by your office.

Your timely adjudication of this claim would be greatly appreciated.

Sincerely,

Manager/Postmaster

Exhibit 7-1

Controversion - Entire Claim

(LETTERHEAD)

Controversion of Claim - Doe, Jane
SSN: 000-00-0000
DOI: 4/4/83

Office of Workers' Compensation Programs
U. S. Department of Labor
(Street address)
(City, State, and Zip Code)

Dear Examiner:

We have controverted the attached claim from our employee, (employee's name), because the injury occurred off postal premises and the employee was not engaged in official "off premise" duties.

Review of items 8 and 13 of the CA-1 will establish that the injury resulted from a fall as the employee exited from her car after returning home from work. Her tour of duty ended forty-five minutes before the injury. She was not engaged in any official business for the Postal Service at the time the injury occurred.

We request, therefore, that Carrier Doe's application for benefits be denied by your office, since her injury clearly lies outside the provisions of the FECA.

Thank you for your consideration of our request.

Very truly yours,

Manager/Postmaster

Controversion of Entire Claim and COP
(LETTERHEAD)
Controversion of Claim - Tilson, Alice
SSN: OOO-00-0000
A12-006234
Office of Workers' Compensation Programs
U.S. Department of Labor
(Street address)
(City, State, and ZIP Code)

The U.S. Postal Service controverts Form CA-1 filed by the subject employee on 6/4/84 and Continuation of Pay for total disability. Ms. Tilson claims that while delivering mail on 5/31/84, she stepped on a rock hurting the bottom of her right foot. The employee obtained medical treatment from her podiatrist, Dr. Henry Fenton, DPM, and was released to sedentary limited duty. On 6/6/84, Ms. Tilson returned to Dr. Fenton and was certified totally disabled from 6/6/84 through 6/8/84.

Our controversion is based on the following facts:

1) Non-industrial right foot surgery 3/9/84 for soft tissue tumors and fibroma (Attachment #1). The employee returned to work on 5/1/84 and complained constantly of pain in the right foot. Even though she was released to full duty by her doctor, Ms. Tilson requested street assistance through 5/31/84 (Attachments #2 and #3).

2) The employee states injury occurred on Thursday. Friday, Saturday and Sunday were non-scheduled days. Injury was reported on Monday. Ms. Tilson reported to Dr. Fenton on 6/15/84 that she did not experience pain in her right foot until approximately 4 days after the injury.

3) Dr. Fenton states in his first report of 6/20/84, Item 18, that findings and diagnosis were not consistent with history or onset of illness (Attachment #4).

It is our belief that the condition is due to recurring soft tissue tumors, not stepping on a rock as claimed. It should be noted that she was in need of additional surgery and had insufficient personal leave to carry her through a recuperation period. The surgery was performed on 6/22/84.

Manager/Postmaster
Attachments

Exhibit 7-2(b)

Controversion - Partial

Controversion of Claim -Doe, John
SSN: 000-00-0000
DOI: 2/1/83
Office of Workers' Compensation Programs
U. S. Department of Labor
(Street address)
City, State, and Zip Code)

Dear Examiner:

We are controverting continuation of pay for February 3, 1983, and February 4, 1983, for the subject claim. Carrier Doe, after repeated requests, has failed to present medical documentation for his absence on those dates.

On February 1, 1983, Carrier Doe sustained a dog bite on his right leg and was found totally disabled by his treating physician on February 1, 1983, and February 2, 1983. Carrier Doe did not report to duty until February 5, 1983. A follow-up call to Dr. _____, by Mr. Doe's Supervisor, (name) , established that Mr. Doe was released to work on February 3, 1983.

It is therefore requested that continuation of pay be denied for February 3, 1983, and February 4, 1983, since the employee has failed to provide medical substantiation for his absence on those dates.

Sincerely,

Manager/Postmaster

(LETTERHEAD)

Subject: Traumatic Claim of (employee's name)
DOI: 7-9-81

Office of Workers' Compensation Programs
U. S. Department of Labor, ESA
(Street address)
(City, state, and Zip Code)

Dear Examiner:

The attached claim from our employee, (employee's name), has been controverted because the injury was not reported on Form CA-1 within the 30-day period required by law.

Item 9 of the report shows that the injury occurred on July 9, 1981. The report was filed on September 5, 1981, as evidenced by item 10.

Since the statutory reporting requirements were not met by (employee's name), we have declined his application for COP leave.

We request that COP be denied, since the employee has failed to meet the reporting requirements of the FECA.

Very truly yours,

Manager/Postmaster

(Letterhead)
Controversion of Claim -Bradford, John
SSN: 000-00-0000
DOI: 4-13-84
Office of Workers' Compensation Programs
U. S. Department of Labor
(Street address)
(City, state, and ZIP Code)

Dear Examiner:

We are controverting 48 hours of Continuation of Pay (COP) for April 27, 1984 through May 6, 1984 claimed by the subject employee.

On April 16, 1984, Mr. Bradford requested medical care for a back injury that allegedly occurred on April 13, 1984. He was released to limited duty by the Industrial Medical Clinic. Mr. Bradford failed to report for an appointment on April 18, returning to the medical clinic April 27, 1984. At the April 27 appointment, Dr. Walsh found Mr. Bradford able to continue on modified duty assignments. However, Mr. Bradford suggested and insisted on taking personal leave to accelerate his healing. Consequently, Dr. Walsh issued off-work-orders on April 27, April 30, May 1, May 2, and May 3 for the sole purpose of substantiating Mr. Bradford's request for personal leave of absence. (See attached doctor's June 19, 1984 letter). Mr. Bradford returned to the post office and filed PS Form 3971 for COP rather than personal leave.

COP should be denied for the period claimed since Dr. Walsh clearly stated that Mr. Bradford was able to work limited duty and knew limited duty assignments were available for him.

It is therefore requested that COP be denied for the period of April 27 through May 6, 1984.

Thank you for your cooperation.

Manager/Postmaster

Attachment

Nonconcurrence to Occupational Claim
(LETTERHEAD)

Doe, John
SSN: 000-00-0000
OWCP
(ADDRESS)

The attached Form CA-2, Notice of Occupational Disease and Claim for Compensation, filed by our employee, John Doe, is forwarded for your adjudication.

We cannot concur with Mr. Doe's claim for compensation due to a severe sinus condition caused by his employment with the Postal Service.

Mr. Doe alleges that he works in a dusty, losed-in environment which causes him to have difficulty breathing, headaches, and sinus congestion.

Dust samplings taken recently (Exhibit A) in the area where Mr. Doe works are well within OSHA standards. The distribution cases where Mr. Doe sorts mail are vacuumed and dusted daily (Exhibit B) and the building is equipped with an air conditioning system which filters the air as well as providing a comfortable temperature (Exhibit C -- Temperature readings). It should be noted that Mr. Doe suffered a sinus condition prior to being employed by the Postal Service (Exhibit D -- copy of preemployment physical).

Mr. Doe's personal statement and the comments submitted by his immediate supervisor are attached as required. Please note the discrepancy between Mr. Doe's statements and those of his supervisor concerning the nature and the duration of the claimant's exposure to substances.

Based on all available information concerning Mr. Doe's claim, we do not believe that his sinus condition is causally related to factors of his employment. We request your thorough review and adjudication of this claim based on the evidence submitted in this letter.

Manager/Postmaster

Attachments

Chapter 8
Negotiating Third Party Settlements

800 Negotiating Third Party Settlements

810 Purpose

This chapter deals with on-the-job injuries to postal employees caused by persons or organizations other than the United States and its agencies. It provides guidance to injury compensation personnel in pursuing collection of damages from third parties. This may be done either by monitoring and cooperating in the efforts by an employee or an employee's attorney, or by pursuing a claim on behalf of the Postal Service when an employee voluntarily assigns a claim. Included with these instructions are sample letters which should be modified to meet local requirements.

820 Background

Congress gave the DOL authority to administratively pursue collection of damages from third parties. In November 1980, the DOL and the USPS entered into an agreement allowing the USPS to pursue collection of such damages. The agencies renewed the agreement in March 1983. Under the present agreement, the USPS may administratively pursue collection of damages in all cases of traumatic injury except when:

a. The injury resulted in the death of an employee;

b. The injury occurred outside of the United States or Canada;

c. The injury occured when the employee was a passenger on a common carrier conveyance;

d. Malpractice or product liability was involved; or

e. More than one employee sustained injury in the same incident (group injuries).

Further, collection of damages should not be pursued when:

a. There has been no payment of COP, nor any payment for wages or medical expenses;

b. The injury arises from assault and battery;

c. The third party, at the time the injury occurred, was an on-duty Federal employee;

d. Acceptance of an assignment would create a conflict of interest.

In those cases where it might be in the best interest of the Postal Service to accept the assignment of a claim such as described above, the control office should consult with the RICPA for advice.

830 Responsibility

The control officer is responsible for the administration of the third party program, including the training of injury compensation personnel to effectively administer third party claims. The control officer may be the injury compensation supervisor/specialist, the control point supervisor, or the senior medical person of a health unit. (See ELM 541.2.)

840 Procedures

841 Identification of Potential Third Party Claim

841.1 Upon receipt of Form CA-1, *Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation,* review it to determine if a third party was involved. If so, determine whether the third party might be legally responsible for the injury.

841.2 In motor vehicle accident cases, the third party may be responsible for both the injury to the Postal Service employee and the damage to the Postal Service vehicle. Therefore, it is essential that the Injury Compensation Supervisor and the MSC Accident Investigator coordinate their efforts in regard to any claims made as a result of the accident, and keep each other informed of the status of any such claims. Initially, the ICS must send a copy of the CA-1 to the MSC Accident Investigator and at the same time request a complete copy of the Accident Investigator's file.

842 Investigation

After identifying a potential third party claim:

a. Determine if the employee's supervisor, postal safety personnel, postal vehicle services personnel, the Inspection Service, local police, or any other

organization conducted an investigation of the incident. If so, obtain a copy of the report and the investigation file;

b. Review the information available in the investigation file and report, and on Form CA-1. (Consult Handbook M-19, *Accident Investigation - Tort Claims,* for information and procedures regarding investigative techniques and guidelines.)

c. If the available information is not adequate, coordinate a supplemental investigation of the incident. Include the following items in the file if at all possible:

1. A detailed, written statement by the injured employee, any witness to the incident, or any other person who may be acquainted with the facts or who is identified as having pertinent information;

2. The name, address, and telephone number of the third party;

3. A detailed description of the place where the incident occurred (including a diagram), and all the circumstances concerning the incident.

843 Notice

After identifying a potential third party claim:

a. Immediately send notice of the injury to the potential third party. (See Exhibit 8-1) If adequate facts are available to identify a third party claim, do not wait for the results of a supplemental investigation before sending notice of the accident.

b. Send a request for information and notice of the government's lien to the injured employee. (See Exhibit 8-2, pages 1-3) Include Form 2562, *Notice of Potential Third Party Claim* (Exhibit 8-3) and Form 2577, *Assignment of Claim* (Exhibit 8-4). If the employee does not respond within 14 days, send a follow-up request through the employee's supervisor. (A photocopy of the original letter marked "second request" can be used.) If the employee does not respond to the follow-up letter, contact him through his supervisor. When Form 2562 is received in response, review it. If complete:

1. Forward Form 2562 to the District Office, OWCP, with the employee's claim for benefits--or, if the claim for benefits has already been forwarded, as soon as possible after receiving the form. Retain a copy for the file. Do not delay submission to OWCP of the claim for benefits pending receipt of third party information. (No further action should be taken where the DOL is responsible for third party recovery efforts.)

2. Determine the course of action to take, based on the employee's answer to the question on Form 2562 as to whether he intends to take action against the third party.

844 Course of Action

844.1 Employee intends to pursue third party recovery and is represented by an attorney.

If Form 2562 or any other information indicates that the employee has retained an attorney:

a. Immediately forward to the employee's attorney:

1. Notice to attorney of the government's lien and necessary information and forms (see Exhibit 8-5, pages 1-3);

2. Request for status (see Exhibit 8-6).

b. If the attorney does not respond within 90 days, contact the attorney directly to obtain a status report on the progress of the case.

c. If recovery has not been made within 90 days, continue to monitor the case. Obtain status reports from the employee's attorney as frequently as necessary. If the attorney does not respond to any follow-up request for status within 90 days, contact the attorney directly. If the attorney does not respond to the letter after 15 days, contact the employee regarding the status of the case.

d. Upon notification from the employee's attorney that the case has been terminated:

e. With payment of damages to the employee: Obtain settlement sheet, Form 2556, *Statement of Recovery* (Exhibit 8-7), and payment due the government. Verify the accuracy of Form 2556 and forward settlement sheet in accordance with ELM 545.87.

1. Without payment of damages to the employee: Verify the nature of termination and either close the file or, if the case appears to have merit, attempt to obtain a voluntary assignment of the claim.

844.2 Employee intends to pursue third party recovery and is not represented by an attorney.

If Form 2562 or other available information shows that the employee intends to pursue the recovery himself and is not represented by an attorney:

a. Furnish the employee notice of the government's lien and necessary information (See Exhibit 8-8).

b. Mail notice of the government's lien to the third party and the third party's insurer, if known (See Exhibit 8-9).

c. At least every 60 days, check with the employee to determine the status of the case.

d. If a recovery has not been made within six months after the accident, or if prior to that time there is information that the action on the claim has been terminated, check with the employee to determine the status of the recovery action. *(See follow-up letter to Exhibit 8-8) If the employee has decided not to seek recovery, or has been unsuccessful in doing so, proceed in accordance with 844c.

e. If the employee makes a recovery, obtain a recovery statement (Form 2556, *Employee's Recovery Statement*, Exhibit 8-7). Review it for accuracy, take the necessary action to correct any errors, and forward the recovery statement together with the payment in accordance with ELM 545.873.

844.3 Employee's Intentions are Unclear

a. Make a second request of the employee for information and notice of government's lien (see Exhibit 8-6) and Form 2559, *Third Party Claim - Information Request* (Exhibit 8-10).

b. If a completed Form 2559 is still not returned within 15 days, contact the employee either directly or through his supervisor to determine what action the employee intends to take against the third party.

c. If the employee indicates that he will seek recovery against the third party, proceed in accordance with 843.2a or 843.2b, as appropriate.

d. If the employee indicates that he will not seek recovery against the third party, or that he is unable to decide what action to take, send the employee a request to assign the claim (see Exhibit 8-11), and Form 2577, *Assignment of Claim to the U.S. Postal Service* (Exhibit 8-4).

e. If the employee declines to make the assignment, refrain from saying or doing anything that could be regarded as pressuring or coercing the employee to agreeing to the assignment. Point out that the Postal Service is not ordering or directing the employee to either sue or assign the claim. However, you may advise the employee that:

1. By assigning the claim to the Postal Service, the employee will enable the Postal Service to attempt to shift the financial liability for the employee's injury from the Postal Service to the true wrongdoer, i.e., the third party.

2. The recovery which the employee will realize for the injury will not be reduced by assigning the claim. An employee is entitled to a minimum of 20% of the net recovery, after the expense of the recovery (attorney's fees, property damage, and court costs only) has been deducted. In addition, the employee is entitled to the amount which exceeds the amount of the government lien paid after the cost of recovery and the employee's 20% entitlement.

3. DOL is authorized to require an assignment of the claim and to terminate compensation payments if the employee refuses to pursue or assign what appears to be a valid third party claim.

f. If the employee still refuses to pursue or assign the claim, refer the file to the RICPA, using Form 2560 (Exhibit 8-12). No further action to obtain an assignment should be taken after the file is referred.

g. If the employee assigns the claim, follow the procedures below.

844.4 Employee Assigns Claim to the Postal Service.

a. Immediately send the employee notice that if contacted by the third party or other parties, he should direct them to the Postal Service (see Exhibit 8-13). Send the third party both a notice that the claim has been assigned to the Postal Service and a request for settlement; also send both to the third party's insuror, if known (see Exhibit 8-14 A or B).

b. If third party or insuror responds, attempt to negotiate a settlement that provides compensation for both the damages sustained by the government (cost of injury compensation benefits) and by the employee (pain and suffering, personal property damage, etc.). Exhibit 8-15, Payment Arrangement with Third Party, may be used if payments are agreed upon.

c. If the third party or insuror does not respond,

After 3 weeks, send a second letter (see Exhibit 8-16). If no response to the second letter is received within 3 weeks, send a third letter (see Exhibit 8-17) advising that the claim may be referred to the Office of Regional Counsel. If no response to these letters is received, review the claim for the likelihood of any recovery and then either close the claim or refer it to the Office of Regional Counsel. Each region may have separate guidelines for which cases to refer; contact the RICPA if information is needed.

845 Settlement of Claims

845.1 The government, with certain adjustments, is entitled to reimbursement of monies paid for injury compensation benefits from any recovery paid by a third party.

845.2 When the settlement of a claim (assigned or not) is imminent:

a. Contact DOL for an up-to-date statement of all disbursements made and determine the amount of any COP paid.

b. If the claim is being handled by an employee or an employee's attorney, advise them of the amount of disbursements and COP.

c. Review Form 2556 (Exhibit 8-7) to ensure that the total reimbursement of the government has been properly included.

d. If dealing with an assigned claim, provide the employee with a copy of the statement of recovery that shows the employee's total entitlement.

e. Process the payment.

f. Furnish the RICPA with a copy of either Form 2556 (Exhibit 8-7) or Form 2557 (Exhibit 8-18) as applicable, on all recoveries made.

846 Disbursement of Recovered Third Party Funds

After a settlement has been made, disburse the funds as follows, with a cover letter similar to Exhibit 8-19.

a. If the third party check includes OWCP payments only, send the check and Form 2556 or 2557, as applicable, directly to the OWCP, unless the check is made payable to the Postal Service. If this is the case, deposit the check and issue a treasury check or a no fee money order to the OWCP.

b. If the third party check includes only COP and OWCP payments (or COP only), send the check, cover letter, Form 2556 or 2557, as applicable to the PDC in accordance with established procedures. In this case the cover letter should be annotated with "NA" in block 3, Net Amount Due Employee.

c. If the third party check includes continuation of pay (COP), OWCP payments, and the employee's share, send the check, cover letter, Form 2556 or 2557, as applicable, to the PDC in accordance with established procedures.

d. If the third party check/monies include only the OWCP payments and the employee's share, (but not COP); payments issued in installments; or checks made payable to the Postmaster, the following procedures apply:

1. Deposit the check/monies in the Postmaster's trust account.

2. Request a receipt Form 3544, *Post Office Receipt for Money*. Include the employee's name and OWCP claim number on the receipt.

3. Forward a memorandum to the accounting office advising them of the proper disbursements to be made along with Form 2556 or 2557, whichever is applicable.

4. Have the accounting office to issue a No Fee Money or Treasury Check which will include the employee's name and OWCP claim number.

e. No disbursements for installment payments should be authorized by the CO until the total expected monies from the third party are collected.

847 Third Party Case File

In addition to the third party register, as outlined in Section 336, a summary sheet should be maintained on the left side of the file for quicker accessibility by the ICS. The following information should be included on the summary sheet:

a. Lost wages, lost hours (COP, DOL compensation, personal leave);

b. Medical expenses;

c. Dollar demand and counter-offer;

d. Other pertinent information for consideration, e.g. financial hardship on the part of the third party; and

e. Settlement

850 Control Point Supervisor, Additional Requirement

All efforts by the control point supervisor concerning these instructions, including case closure and settlement, must be coordinated with the assigned control office.

860 Recovery Assistance

861 Control Officer

861.1 Responsibility

.11 Seeking Assistance. Assistance in pursuing recovery is available from the RICPA and from the Postal Service attorneys. It is the control officer's responsibility to seek out assistance whenever the likelihood of recovery would realistically be enhanced.

.12 Referral to RICPA or Office of Regional Counsel. If the control officer determines that assistance on a particular case is needed, such assistance should first be sought through RICPA; if necessary, the case

will subsequently be referred to Postal Service attorneys for assistance.

.13 Monitoring Status of a Referred Case. The case remains the responsibility of the control officer even after it has been referred for assistance, and should be monitored in the same manner as that described in Section 844.1.

861.2 Guidelines For Seeking Assistance

.21 Assistance from the RICPA, Office of Regional Counsel, and Claims Division is available either informally (without review of the case file), or formally (with review of the case file). Informal assistance may be obtained by telephone or by submitting a two-way memorandum (Optional Form 27), outlining the factual or legal issue or making a specific request. Assistance may be in the form of advice or by direct contact or correspondence with the third party or others, whichever is deemed appropriate. The party involved may respond under the "Reply Message" section of Form 27 and return this form to the control officer.

.22 When to Seek Assistance. In ascertaining whether recovery assistance might realistically enhance the likelihood of recovery, consider the following three factors:

a. When government expenses are in excess of $2,500, obtain confirmation of liability evaluation and settlement valuation from the RICPA or Office of Regional Counsel, prior to taking any recovery action.

b. When the nature of damages or question of law create issues which the control officer is unfamiliar with, the control officer should first seek informal advice and then refer the file to RICPA or the Regional Counsel, as appropriate under regional procedures.

c. When a third party or the third party's insurance company or attorney refuses to recognize the validity of the assignment of claim, assistance should be sought.

861.3 Guidelines For Closing Out Cases Without Seeking Assistance

.31 Claims for Special Damages. Regardless of the special damages incurred, all assigned claims should be closed out at the local level if:

a. The third party cannot be identified or located; or

b. There is little promise of recovery based on the third party's lack of assets or insurance. Examples: senior citizens with fixed incomes; individuals on welfare or unemployment compensation.

c. The pursuit of the third party claim results in more expenses incurred to recover those costs than the costs themselves.

.32 Claims Less Than $100.00. In addition to those standards above, assigned claims where the cost to the Postal Service and the Department of Labor is less than, or not expected to exceed $100.00 should be closed out when:

a. It is doubtful that the third party is liable; or

b. The third party or the third party's attorney or insurance company has denied the claim; and the denial is based on a reasonable interpretation of the facts of the case and is not spurious.

.33 Claims More Than $100.00. Assigned claims where the cost to the Postal Service and the Department of Labor exceeds, or is expected to exceed $100.00 should be closed out when it is doubtful that the third party is liable, unless one of the following is applicable:

a. A serious injury was sustained; or

b. An injury was sustained which, by nature, indicates a distinct possibility of recurrence.

.34 Exception. An assigned claim should not be closed out at the local level if an insurance company refuses to respond or discuss the claim or refuses to recognize the Postal Service's authority to handle the claim. (See Section 861.21 [c])

862 RICPA

862.1 Responsibility

.11 Providing Assistance. It is the responsibility of the RICPA to provide assistance in pursuing recoveries.

.12 Referral to Office of Regional Counsel

a. It is the responsibility of the RICPA to refer cases to the Office of Regional Counsel when the likelihood of recovery would realistically be enhanced by assistance from a Postal Service attorney.

b. The RICPA may permit control officers to seek assistance directly from the Office of Regional Counsel.

.13 Reporting Status of Cases. When a case has been referred to the RICPA for assistance, it is the responsibility of the RICPA to keep the control officer advised of the status of the case in a reasonable manner and at reasonable intervals. If the RICPA refers the case to the Office of Regional Counsel, the control officer should be advised of this action. RICPA's responsibility to report the status of cases terminates when:

a. The case has been referred to the Office of Regional Counsel and the control officer has been notified; or

b. The case file is returned to the control officer.

862.2 Guidelines for Providing Assistance. The RICPA may provide assistance informally or formally. The RICPA may give assistance by providing advice to the control officer or by actually contacting or corresponding with the third party or others.

863 Office of the Regional Counsel

863.1 Responsibility

.11 Providing Assistance. It is the responsibility of the Office of the Regional Counsel to provide assistance in making third party recoveries when this assistance is requested by the control officer or the RICPA.

.12 Referral to Claims Division, Law Department, Headquarters.

.121 Claims More Than $2,500

Cases where the government's expenses exceed $2,500, must be referred to the Claims Division, prior to closing such cases as uncollectible.

.122 Litigation

It is the responsibility of the Office of Regional Counsel to promptly seek advice from or refer cases to the Claims Division if efforts made by the Office of Regional Counsel have not resulted in a reasonable recovery and where litigation might be effective. When it is determined to refer a claim with a request for litigation, it is the responsibility of the Office of Regional Counsel to provide a draft request for litigation and a sample complaint.

863.13 Reporting Status of Case. When a case file has been referred to the Office of Regional Counsel for assistance, that office is responsible for advising the control officer of the status of the case at reasonable intervals. If the Office of Regional Counsel refers the case file to the Claims Division, the control officer should be notified accordingly. This responsibility terminates when:

a. The case is referred to the Claims Division and the control officer is notified of this action; or

b. The case file is returned to the control officer.

863.2 Guidelines for Providing Assistance. The Office of Regional Counsel may provide assistance, as needed on a case-by-case basis, either informally or formally. This office may give assistance by providing advice to the control officer or by actually contacting or corresponding with the third party or others.

864 Claims Division, Law Department, Headquarters

864.1 Responsibility

.11 Providing Assistance. It is the responsibility of the Claims Division to:

a. Provide Guidance and Advice. Upon request, Claims Division attorneys will provide guidance and assistance concerning settlement valuation, evaluation of liability and interpretation of applicable federal laws.

b. Review Claims More than $2,500 Prior To Closing. When government expenses for a claim exceed $2,500, Claims Division attorneys will review claims to confirm liability evaluation and settlement valuation.

864.2 Litigation. The Claims Division may provide assistance in pursuit of those cases where the Office of Regional Counsel was unable to effect a reasonable recovery and where litigation of the case would have a reasonable possibility of success. In cases where litigation is considered necessary and effective, the Claims Division will coordinate a request for litigation with the Department of Labor and the Department of Justice. The Claims Division will also take or delegate action as necessary during the course of litigation.

864.3 Reporting Status of Case to Control Officer. When a case file has been referred to the Claims Division for assistance, it is the responsibility of the Claims Division to advise the control officer of the status of the case at reasonable intervals. Upon request, the Regional Office may also be kept advised. The Claims Division's responsibility terminates when:

a. The case is closed; or

b. The case file is returned to the control officer.

870 DELEGATION OF AUTHORITY

The following are authorized to accept voluntary assignments of an employee's claim against third parties and sign releases on behalf of the Postal Service when requested by a third party or insurance carrier:

a. Manager, Injury Compensation Branch

b. RICPA

c. Control Officer

d. Control Point Supervisor

e. Regional Counsel

f. Assistant General Counsel, Claims Division

880 Negotiating Third Party Settlements

881 Purpose

Because of the Postal Service's active involvement with and commitment to the Third Party Program, this section furnishes helpful hints to the ICS in the art of negotiating settlements for third party claims.

882 **Definitions of Terms as Used in the Injury Compensation Program**

a. Negligence -- a breach of a legal duty which result in an injury. Example: a property owner has a legal duty to maintain his property in reasonably safe condition. Failure to do so is a breach of that duty. If that breach causes injury (i.e., it is the "proximate cause" of injury), the property owner is liable.

b. Comparative Negligence -- the concept of comparing the degree of wrongdoing of both the third party and the USPS employee. The total recovery amount is reduced by the proportion of negligence by the employee.

c. Contributory Negligence -- the concept which recognizes the injured party's contribution to an injury. In certain states, contributory negligence by our employee bars recovery of damages.

d. Damages -- measure of the injury. Under the Third Party Program, the ICS tries to recover compensatory damages (compensation for the injury). Two types of compensatory damages are:

1. Special damages (or "specials") -- damages to which an exact amount can be assigned, e.g., medical expenses, COP, property damage, DOL payments.

2. General damages -- damages to which an exact amount cannot be assigned. This includes pain, suffering, interference with employee's normal activities, etc.

e. Lien -- a claim on the recovery in order to satisfy a debt. Example: USPS has a lien on the employee's third party recovery equal to the amount of medical expenses, COP, and DOL benefits paid.

f. Subrogation -- The acquisition by one person of the rights of another person to bring a claim. This can occur only if the person making payment is legally obligated to do so. Technically, the Postal Service is not subrogated to an injured employee's rights against the third party. Rather, it has a lien against any recovery that is made.

g. Third Party -- a person or organization other than the United States and its agencies who is

believed to be responsible for injury to a postal employee who was in the performance of his employment.

h. Tort -- any wrongful act (including negligence) committed by a third party which causes injury to our employee.

883 Negotiation Strategy

883.1 What is the process in which you will be engaging? You and the other side are trying to reach an agreement as to the value of an item - an injury with its accompanying pain, suffering, and inconvenience - which has no fixed price. Where a third party claim exists, normally both sides are interested in amicably settling the claim and avoiding the inconvenience and expense of litigation.

883.2 No single negotiating method is best. In negotiating, the correct technique is the one that works best for you. Use techniques that you are comfortable with and that prove effective. Occasionally, try something new to see if it improves your effectiveness as a negotiator.

883.3 Be Credible. Your position as a federal employee carries with it a natural implication of honesty and credibility. Maintain that credibility by using terms of the trade. You will convey the impression that you know what you are doing, and you will feel more confident about yourself and your job, if you:

a. Use proper legal terminology, such as "negligence," "tort," "absolute liability," "comparative negligence," and "contributory negligence."

b. Use the shorthand terminology familiar to the other side, such as "specials," "medicals," "P.D.," "med pay," and "pain and suffering."

c. Use negotiating tactics familiar to the other side.

883.4 Know your case before you begin to negotiate.

.41 You should review the complete file so that you know and can discuss:

a. All the details concerning the accident and the injury.

b. The legal basis for the claim, i.e., what the third party did or did not do and how this caused the injury.

c. The nature and extent of the employee's injury, and the:

d. Special damages, including:

1. Property damage.

2. Doctor's bills and future (projected) doctor bills.

3. Hospital bills.

4. Drug expenses.

5. Other medical expenses.

6. Lost earning capacity, even if wholly or partially compensated by means of:

(a) C.O.P.

(b) D.O.L. payments

(c) Annual or sick leave taken

(d) Schedule award

e. General damages, including:

1. Pain.

2. Suffering.

3. Embarrassment.

4. Temporary and permanent limitation of use of part of the body.

5. Interference with the employee's normal activities, such as sports, hobbies, and home life.

.42 Be prepared to emphasize in the settlement negotiations the strong points of the claim.

.43 Prepare replies or rebuttals of any weaknesses to which the other side may refer.

883.5 Negotiating Tactics

.51 Try to get the other side to make the first settlement offer. Occasionally, they will surprise you and offer more than the minimum you were prepared to accept. Nevertheless, do not rush to accept. Negotiate the best settlement that can be reached. Remember that it is in the best interest of the Postal Service to obtain the maximum; the greater the settlement, the larger the surplus - and a surplus is insurance against expenditures if the employee's injury recurs.

.52 Be courteous. Try to be on a first-name basis with the persons with whom you are negotiating. However, do not do so if they show no such inclination, or if there is any possibility that it would be offensive. In those cases, be more formal and use the appropriate form of address (Dr., Ms., Miss, Mrs., Mr.) and their last name. Also, never address them in an overly familiar fashion such as calling them "dear," "darling," or "sonny," or in any manner that could be construed as belittling or sexist.

.53 Make high, original settlement demands. The other side will never offer to pay more than you demand. Normally, you can expect the other side at first to offer to pay nothing at all, or perhaps only the "out-of-pocket" expenses. If you start high and they start low, a settlement can usually be reached at an acceptable point somewhere in between. If your original demand is at or below a fair settlement amount, there is no room for negotiating.

.54 Do not necessarily believe everything the other side says. They too will be trying to emphasize the facts and laws which are favorable to them, and to gloss over matters which could increase the possibility of liability and the extent of the damages.

.55 If at first it appears that a mutually satisfactory settlement cannot be reached, do not give up. To avoid litigation, both sides should be willing to give a little. If the parties are not very far apart after negotiations, impasses frequently can be resolved by "splitting the difference", that is, settling for the amount which is halfway between the lowest settlement demand and the highest settlement offer.

.56 Do not feel that you must accept whatever is offered. If no offer is made, or if the maximum offer is unacceptably low (taking into consideration all of the

factors involved in the claim), and all attempts to negotiate a fair settlement have been made, refer the claim to your Regional Counsel.

Notice to Third Party of Accident

Employee:_____
Date of Injury:_____

Dear

This is to give you notice that the above named postal employee was injured under circumstances which we feel indicate you may be legally liable. The circumstances are as follows:

When we receive documentation of the extent of the injury, further action may be taken. This may come from the employee or a private attorney retained by the employee, or if the employee prefers she(he) may assign her(his) claim to this office for action.

Any claim will include special damages (for the medical bills, any personal property loss, and any lost wages) and general damages (pain and suffering, inconvenience).

If you have any questions, you, your insurance company, or your attorney may call this office at _____ for further information.

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

cc: OWCP, _____

Request for Information from Employee and
Notice of Government's Lien

File Number:_____
Date of Injury:_____

Our records show that on the above date you sustained an injury under circumstances which may place liability for damages upon a party other than the United States.

Under the provisions of Section 8131 of Title 5, United States Code, the Secretary of Labor can and will require a workers' compensation beneficiary to prosecute an action for damages in his/her own name when injury or death occurs under circumstances which indicate legal liability to pay damages on a party other than the government. When damages are recovered from such a party, the beneficiary must, out of the damages recovered, reimburse the United States for any payments made to the beneficiary or on the beneficiary's behalf. Nevertheless, in all cases you will be entitled to a minimum of 20% of the net recovery.

For our records, a statement is required from you as to whether you have presented a claim for damages as a result of this injury against anyone other than the Postal Service or the Office of Workers' Compensation Programs. It is requested that you answer the questions on the attached form, Third Party Claim-Information Request, and promptly return it to this office.

If you have initiated a third-party action, you should contact us for a statement of any COP and OWCP disbursements made to you or on your behalf before you make a final settlement. These disbursements must be repaid from any recovery you make from the third party (the person or persons responsible for the injury).

If you wish to discuss this matter or desire us to assist you, please contact _____ at _____.
Name Telephone No.

Sincerely,

Attachments

cc: District Office, OWCP

Exhibit 8-2

ATTACHMENT
INFORMATION ABOUT YOUR CLAIM

We strongly encourage you to pursue this claim, either by yourself, through a lawyer, or by assigning it to the Postal Service.

Damages Recoverable: Under the law, if the third party is liable, you are entitled to payment of what is called "compensatory damages." This payment compensates for out-of-pocket expenses (yours and the government's) and for pain and suffering.

How to Pursue Collection of Damages: Your choices are as follows:

(1) Retain a lawyer. Your own lawyer can usually obtain the best settlement.

Lawyers generally charge little or no money for an initial discussion of your case. If you hire a lawyer you may pay him "up front," but lawyers generally take a percentage of the recovery, if and when a settlement or other recovery is made. This is called a "contingent fee;" whether the lawyer receives pay depends on whether any money is recovered.

To find a lawyer, you can ask friends for recommendations. You might check with your union steward or with other postal employees. In the yellow pages, the state or local bar association will generally have a listing for referral service.

(2) Pursue the claim yourself. To do this, contact the third party directly; the amount of recovery sought is up to you. However, you should take into consideration that you are obligated to reimburse the government for payments made to you or in your behalf, but you are always entitled to keep at least 1/5 of any recovery.

(3) Assign the claim to the Postal Service. You may assign all recovery rights to the Postal Service. We will then pursue the case for you. If the assignment is accepted and we make a recovery, at least 1/5 will be yours. In addition to the 1/5 guarantee, all amounts beyond our out-of-pocket expenses will also be yours. No fee is charged.

Even after you have attempted pursuit on your own and been unsuccessful, you may assign your claim to the Postal Service.

(4) Refuse to pursue the claim: We strongly encourage pursuit, but it is voluntary. However, if you do not follow one of the three above alternatives, you may be denied compensation for treatment of this injury or a recurrence; the Department of Labor administers this provision.

When damages are recovered: Regardless of your choice for pursuit of the claim, the government is always entitled to be paid back for: (1) Medical costs, (2) COP, (3) Compensation paid after COP is exhausted, (4) Schedule awards, and (5) Any other benefits paid pursuant to the Federal Employees' Compensation Act.

This requirement is a provision of law and cannot be waived or compromised. It exists when there is a recovery of any type.

The amount which must be paid back can be obtained from the Injury Compensation Office. Because of the pay back requirement, it's a good idea to check with us just before you accept a settlement.

The amount paid back may be reduced if you hire a lawyer. You should check with us for information in these cases.

A Statement of Recovery form must be completed if recovery is made by yourself or your lawyer. The proper form will be sent to you when you notify us of your decision as to how you will proceed on your claim.

U.S. POSTAL SERVICE
INJURY COMPENSATION PROGRAM -- NOTICE OF POTENTIAL THIRD PARTY CLAIM
(See instructions on reverse)

1. DATE	
2. Name of Employee	4. Home Address *(Include Apt. No. and ZIP Code)*
3. Home Phone *(include Area Code)*	
5. Type of Injury	6. Date and Location of Injury
7. Office of Employment	8. Employee's Title
9. Contact Point at Employing Office *(Name and Phone)*	10. Employee's Social Security No.
11. Prepared by *(Printed Name and Signature)*	12. OWCP File No.
13. Brief Description of Incident	
14. Does the Employee or Beneficiary(ies) intend to take action against the Third Party? ☐ YES ☐ NO *(If "No", specify why not)*	
15. Third Party a. Name	b. Address *(Include Apt. No. and ZIP Code)*
c. Name and Address of Insurance Company *(Include Suite No.)*	16. Name and Address of Attending Physician *(Apt./Suite No.)*
17. Law Enforcement Agency Notified	18. Name and Address of Attorney representing employee in Third Party Action *(Include Apt./Suite No.)*

19. EMPLOYEE OR REPRESENTATIVE

Wage records, medical records, and other pertinent information may be released to my attorney. ☐ YES ☐ NO

a. Date Signed	b. Printed Name	c. Signature

PS Form 2562
Mar. 1981

Exhibit 8-3

READEX Microfilm

U.S. POSTAL SERVICE

ASSIGNMENT OF CLAIM TO THE USPS

As a result of my applying for and receiving benefits under the provisions of the Federal Employees' Compensation Act (5 U.S.C. 8101-50), and because I do not wish to prosecute an action in my own name to recover damages, I (name)_____, of (address)_____, City of _____, County of _____, State of _____, hereby voluntarily assign to the United States Postal Service all of my right, title and interest in any claim, demand, or cause of action which I may have against (name of third party)_____, or any other person, as a result of an injury I sustained on (date)_____, at (location)_____, while in the performance of my duties as an employee of the United States Postal Service.

I understand that in the event of recovery of damages by the United States Postal Service under this assignment, I am entitled to one-fifth of the net amount of recovery after the expenses thereof have been deducted and to any surplus remaining as provided by Section 8131 of the Federal Employees' Compensation Act.

I understand that I have the right to pursue an action to recover damages by myself or by an attorney of my own choice, but I hereby am assigning that right to the United States Postal Service. Upon acceptance of this assignment, the United States Postal Service shall have full and complete authority to take whatever action on this claim it considers appropriate, and may institute legal action, settle or compromise the claim or any suit, or decline to institute suit, or to take any other action.

I hereby authorize the United States Postal Service to furnish all records, medical and other reports, statements made by myself and other papers relating to my injury to the parties against whom claim is made, their representatives, and insurance companies for the purpose of effectuating a settlement of the assigned claim.

IN WITNESS WHEREOF, I have signed this assignment this _____ day of _____, 19____.

_____
(Signature)

Pursuant to the authority granted by 39 C.F.R. 224.2(b)(1)(i) and other Postal Regulations, I hereby accept the above assignment.

Dated _____

_____
(Signature)

_____
(Title)

PS Form 2577
Feb. 1981

Notice to Attorney of Government's Lien

File Number:_____
Employee:_____
Date of Injury:_____

We have been advised that you have been retained to represent the above-named employee with respect to the third-party damage claim arising from the above-referenced injury. Copies of the reports contained in our file are enclosed for your information. If continuation of pay by the employing agency and/or OWCP disbursements have been made in this case, you will also find a statement showing the disbursements made to date. Also enclosed is Form 2556, Statement of Recovery, for your use. Upon request, we will furnish you an updated statement of disbursements, or copies of additional reports.

If you have any questions concerning the third party aspects of this case, or the obligations and responsibilities imposed by Sections 8131 and 8132 of Title 5, United States Code, please contact _____ (Name) at _____ (Telephone No.).

Sincerely,

Enclosures

cc: District Office, OWCP

The purpose of this enclosure is to provide you with specific information of which you may not be aware as to the implications of the Federal Worker's Compensation Laws.

(1) Assistance that the Postal Service can provide: Although most of our records and investigations are not public information, all information available will be forwarded to you upon request since you represent our employee .

Items of particular interest might include the employee's report, a supervisor's investigation, investigations by safety personnel, copies of medical bills and medical reports documenting the injury. Not all items are available in each case. Items immediately available will be released.

(2) Lien against any recovery: We have a lien upon any recovery; the exact amount of the lien depends upon the results of certain computations.

Specials which may comprise our lien are medical bills, Continuation of Pay, schedule awards, and compensation benefits. An update of these specials can be obtained upon request. This lien is against any recovery, regardless of whether it is for special and/or general damages.

(3) Basis of the Federal lien: Our lien is based upon 5 U.S.C. 8132, which states:

". . . If an injury for which FECA compensation is caused under circumstances creating a legal liability in a person other than the United States to pay damages, and the employee receives money in satisfaction of that liability, after deducting the costs of suit and a reasonable attorney's fee, the employee shall refund to the United States the amount of compensation paid by the United States and credit any surplus or future payments of compensation payable for the same injury."

(4) Statement of recovery: We are providing a PS Form 2556, Statement of Recovery. If and when a settlement is made, this statement of recovery must be completed. Full instructions for completion are on the reverse of the form; however, if you need any additional information or assistance, please call this office.

(5) How to compute the amount of the federal lien: The Statement of Recovery, PS Form 2556, is used to compute the amount of the lien and of the employee's recovery.

Our lien is not the total amount of our expenses; we allow a deduction to the employee for the payment of attorney fees. The allowance for attorney's fee goes to the employee.

5) Please ensure that our lien is satisfied before distributing any recovery. Federal law prohibits the distribution of a recovery without first assuring satisfaction of the Federal lien.

Exhibit 8-5

Request for Status and Transmittal of Information

File Number:_____
Employee:_____
Date of Injury:_____

[ ] We will appreciate a report concerning the present status of this third-party damage claim. If possible, advise the date that you expect the matter to be concluded.

[ ] We are enclosing copies of additional reports from our file which may be of assistance to you.

[ ] There is enclosed a statement of the disbursements made to the employee.

Sincerely,

Enclosures

cc: District Office, OWCP

S. POSTAL SERVICE

THIRD PARTY STATEMENT OF RECOVERY ▶ *SEE INSTRUCTIONS ON REVERSE*

File No.

Claimant	Date of Injury/Death	MSC	Finance No.

1. Gross Recovery	$
2. Less Property Damage	
3. Balance	
4. Less Attorney's Fee *(Fee is _____ % of line 3)*	
5. Balance	
6. Less Court Costs *(Must be itemized)*	
7. Balance *(Adjusted Gross Recovery)*	
8. Less 1/5 *(20% of line 7)*	
9. Balance	
10. Continuation of Pay *(COP)*	
11. Balance	
12. Less Payment to Public Health Service *(or other Federal medical facility)*	
13. Balance	
14. Less Medical Expenses Paid by the Claimant *(Must be itemized)*	
15. Balance	
16. OWCP Disbursements *(Including compensation and medical but excluding COP)* or line 15 whichever is less	
17. Surplus *(Line 15 less line 16)*	
18. Amount from line 10	
19. Amount from line 16	
20. Total Government Lien *(Line 18 plus line 19)*	
21. Less Government Allowance for Attorney's Fee *(Retained by claimant)*	
22. Amount to be refunded *(Enclose check or money order payable to U.S. Postal Service)*	

For Official Use Only		
	23. Amount from line 10	
	24. Less Government's Allowance for Attorney's Fee *(Use percentage on line 4)*	
	25. Net Refund to USPS	
	26. Amount from line 16	
	27. Less Government's Allowance for Attorney's Fee *(Use percentage on line 4)*	
	28. Net Refund to OWCP	
	29. Total Refund *(Add lines 25 & 28, total must be same as line 22)*	$

PS Form **2556**, Oct. 1982

Exhibit 8-7

Instructions

(Disbursement must be made in accordance with 5 U.S.C. 8132. Also, provide the employee with a copy of this form. **NOTE:** Shaded area for USPS Use Only.)

Property Damage, (line 2): A reasonable amount for clothing or other personal belongings damaged or destroyed in an accident may be deducted. These amounts must be itemized. If an automobile or other vehicle is damaged or destroyed, then more tangible evidence of such damage is required. The year, make, model, and Blue Book value of the vehicle must be furnished. A copy of the repair bill will suffice if the vehicle was not totally destroyed.

Attorney's Fee, (line 4): Deduct the attorney's fee in line 4 from the balance shown in line 3. The attorney's fee as a percentage of line 3 must also be shown.

Court Costs, (line 6): These consist of such items as filing fees, witness fees, actual costs of collection, or any payments to physicians for expert testimony as opposed to payment for treatment. *(Payment for medical treatment comes under line 12 and/or 14.)* All items must be itemized.

20% Guarantee, (line 8): This amount is turned over to the claimant and is not subject to any deductions.

Continuation of Pay (COP), (line 10): If pay was continued by the employing agency as provided by 5 U.S.C. 8118, the employing agency is entitled to be reimbursed out of any third party recovery resulting from the employment-related injury.

Public Health Service, (line 12): Refund made to a Federal medical facility for medical treatment is deductible under line 12. The claim of the Federal medical facility is separate and apart from the claim of the OWCP.

Medical Expense Paid Direct, (line 14): This consists of any medical expenses paid by the claimant other than those paid by OWCP or by an insurance carrier. It does not include items paid by the claimant for which the claimant was subsequently reimbursed by the OWCP or by an insurance carrier. Itemize all items submitted for credits and deduction in line 14 or attach copies of paid bills. A lump sum amount will not be accepted for credit.

Surplus, (line 17): This surplus, which is retained by the claimant, is the amount against which the OWCP will credit any future compensation payments or additional medical expenses payable on account of the same injury or death.

Government Allowance for Attorney's Fee, (line 21): The Government contributes a portion of its refund to the claimant as an attorney fee. This fee is based upon the OWCP's disbursements, COP, or other amount as shown in lines 10 and 16, and is computed by multiplying the amount on line 20 by the percentage shown on line 4, if line 4 is considered reasonable.

Total Refund, (line 22): This represents the amount to be refunded to the Government for OWCP disbursements and COP, if any, by the employing agency under 5 U.S.C. 8118. Refund check must be made payable to the U.S. Postal Service.

Disbursement Information, (lines 23 through 29): To be completed by control office/point personnel upon receipt of reimbursement.

Example: If attorney's fee is 30% of gross recovery, then lines 24 and 27 would be 30% of lines 23 and 26, respectively.

PS Form **2556**, Oct. 1982 *(Reverse)* U.S. GOVERNMENT PRINTING OFFICE: 1983—654-776

Notice to Employee of Government's Lien

File Number:_____
Date of Injury:_____

Our records show that you have presented or you intend to present a claim for damages against a third party apparently responsible for your injury.

The Federal Employees' Compensation Act provides that the United States must be reimbursed out of any third-party recovery, for any disbursements made to you or on your behalf by the United States. Therefore, you should include as damages in your claim the disbursements indicated on the attached Form 2557, Employee's Third Party Recovery Statement, and any other disbursements you received or that were made in your behalf. If you receive additional treatment, compensation, or continuation of pay, contact this office for an up-to-date statement of disbursements before settling your claim.

This office must be notified of any recovery you obtain. Completion and submission of the attached form will serve as notification of a recovery obtained without the services of an attorney. It will also enable you to determine the amount of any refund you must pay to the Postal Service.

If you should retain the services of an attorney to assist you in your third-party claim, please advise this office immediately and provide the attorney's name and complete address.

If you wish to discuss this matter or desire us to assist you, please contact _____ (Name) at _____ (Telephone No.).

Sincerely,

Attachment

cc: District Office, OWCP

Exhibit 8-8

EL-505, TL-3, 10-31-85

UNITED STATES POSTAL SERVICE

Washington, DC 20260

DATE:

OUR REF:

SUBJECT: Third Party Injury Compensation Claim
Date of Injury:

TO

On _____ you were injured on the job. We encouraged you to pursue a third party claim and you indicated that you would attempt to pursue the claim on your own.

We haven't heard from you. Have you recovered on the claim yet? Please don't forget the pay-back requirement for government expenses explained in our first letter to you.

Please give us the status of this case. A postage-paid envelope is enclosed for your reply.

If you wish further information, feel free to call us at _____ . Also, remember that you may retain a lawyer or assign the claim to us at any time; a Form 2577 is attached should you wish to make an assignment now.

_____
Injury Compensation Specialist
Injury Compensation Office

Attachment

cc: OWCP
bcc: Suspense (4 weeks)

Exhibit 8-8

Notice to Third Party of Government's Lien

File Number:_____
Employee:_____
Date of Injury:_____
Your Insured:_____
Policy Number:_____

We have been informed that the postal employee named above will make, or has made, a claim for damages as a result of an incident involving you (your insured) that occurred on the date shown.

The injury occurred in the performance of Federal employment and comes under the Federal Employees' Compensation Act (5 U.S.C. 8101 et seq.). Section 8132 of Title 5 of the United States Code requires that the government must be reimbursed for payments made to or on behalf of a beneficiary out of the recovery made from a third party. This section also states, "No court, insurer, attorney, or other person shall pay or distribute to the beneficiary or his designee the proceeds of such suit or settlement without first satisfying or assuring satisfaction of the interest of the United States."

Because of the Government's financial interest in the outcome of this case, please request a statement from this office of the Government's disbursements before distributing any proceeds in settlement of this case.

Sincerely,

cc: District Office, OWCP

U.S. POSTAL SERVICE
THIRD PARTY CLAIM—INFORMATION REQUEST

Section 8131 of Title 5, United States Code, provides that when damages are recovered the United States shall be reimbursed for payments it made on account of the injury.

1. Have you presented a claim or instituted suit for damages against any person or persons apparently responsible for your injury? ☐YES ☐NO
(If yes, give the third party's name and address and the name and address of the insurance carrier, if known.)

THIRD PARTY'S NAME AND ADDRESS	INSURANCE CARRIER'S NAME AND ADDRESS

2. Have you retained an attorney with regard to a possible action against any person or persons apparently responsible for your injury? ☐YES ☐NO
(If yes, give the attorney's name and address.)

3. If you have not filed a claim for damages, state your reasons, in full detail, for not doing so.

4. Have damages been recovered? ☐YES ☐NO *(If yes, please furnish the following information.)*

a. Total amount recovered . . . . . $_____

b. Personal property damage, if any . . . . . $_____

c. Medical expenses paid by you personally *(Do not include those paid or reimbursed by OWCP or an insurance carrier.)* *(Attach itemization.)* . . . . . $_____

d. Attorney's fee, if any . . . . . $_____

DATE OF JUDGMENT OR RELEASE	5. SIGNATURE	DATE

The Federal Employee's Compensation Act, as amended (5 USC 8101, *et seq.*) is administered by the Office of Workers' Compensation Program of the U.S. Department of Labor. In accordance with this responsibility, the office collects and maintains personal information on claimants and their immediate families. The information will be used to determine eligibility for and the amount of benefits payable under the Act. The Postal Service uses the information in handling matters relating, directly or indirectly, to the subject matter of the claim in accordance with the provisions of 20 CFR 10. In addition, this information may be disclosed to an appropriate law enforcement agency for investigative or prosecutive purposes, to a congressional office at your request, to OMB for review of private relief legislation, to a labor organization as required by the NLRA, and where pertinent, in a legal proceeding to which the Postal Service is a party. Failure to provide the information requested may delay the adjudication process, or result in an unfavorable decision or a reduced level of benefits. (however, disclosure of the social security number is voluntary and will not cause such delays; its only purposes are to enable the Postal Service to account for program costs and to verify the dollar amount of payments due the Department of Labor).

PS Form 2559
Feb. 1981

Assign Claim

Third Party Claim
Date of Injury:

We have received information from you that you do not intend to take action against the third party in your on-the-job injury.

Since you do not intend to pursue the third party claim, we therefore request you assign the claim to the U.S. Postal Service so that we may recover expenses due to your injury. Even if the Postal Service pursues this claim, you will be entitled to 20% of the net recovery. In addition to the guarantee of 20%, all amounts beyond our disbursements will also be yours. Please note that should you refuse to pursue the claim or assign it to the Postal Service, the U.S. Department of Labor, Office of Workers' Compensation, may deny your compensation benefits.

If assigning the claim to the U.S. Postal Service, please complete and sign the attached form and return it to this office in the enclosed return envelope. We will not formally advise you of the status of the claim until we obtain a recovery or terminate collection. However, you may always obtain information on how the claim is going by calling the Injury Compensation Office at _____.

_____
Injury Compensation Specialist
Injury Compensation Office

Attachment

bcc: File
Suspense (2 weeks)

U.S. POSTAL SERVICE
REFERRAL OF THIRD PARTY MATERIAL

TO:	FROM:

EMPLOYEE'S NAME	CASE NO.	DATE OF SUBMISSION

A. CA Forms (Front and Back)

☐ CA-1 ☐ CA-2 ☐ CA-3 ☐ CA-4 ☐ CA-5 ☐ CA-7

☐ Other *(Identify)*

B. Witness Statements and Accident Reports

☐ Reverse of CA-1 or CA-2 ☐ Other *(Identify)*

C. Medical Reports

☐ CA-16 (Reverse) ☐ CA-20 ☐ CA-20a

☐ Other *(Identify)*

D. Correspondence From:

☐ Attorney dated _____ ☐ Claimant dated _____

☐ Other *(Identify)*

E. Award of Compensation

☐ CA-1048 ☐ CA-1049 ☐ CA-180 ☐ CA-181

☐ Other *(Identify)*

F. Settlement

☐ Settlement has been made in this case. Attached is a copy of:

☐ Claimant's recovery statement ☐ Recovery Letter I

G. Claimant returned to work on _____.

PS Form 2560
Feb. 1981

Exhibit 8-12

Notice to Employee After Assigning Claim

Third Party Claim
Date of Injury:

By assigning your Third Party Claim to the Postal Service, you have authorized us to assume your interest for the collection of your medical bills, lost work time due to the injury, your damaged clothing, and pain and suffering you may have experienced.

Since you have assigned your full personal injury claim to the Postal Service, it is important that you not discuss the claim with the homeowner/customer or their representative. If anyone questions you regarding this matter, please refer them to my office at _____.

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

cc: File

Injuries Not Related to Dogs;
First Request for Settlement of Claims

Dear

On _____, our employee Carrier _____, was injured on your premises under the following circumstances:

_____

_____

We feel that you breached your legal duty to our carrier by failing to keep your premises reasonably safe, in that you

_____

_____

There was no negligence on the part of our employee, who used reasonable care.

Pursuant to federal law, our employee assigned all rights to his/her personal injury claim to the Postal Service. As assignee, we therefore have sole and full authority to handle this claim. Our authority flows from 5 USC 8131, 8132; 20 CFR 10.500 et seq.; and 4 CFR 102.2 et seq.

*As we feel that there is liability, we present our claim for damages. We feel that a very reasonable value for our claim is _____. This represents special damages (_____ medicals and _____ lost wages), with the remainder allocated to general damages (pain and suffering).

We have the authority to settle this claim locally and would prefer to do so. Please contact me at _____. Should you prefer to mail your check or money order (made payable to the U.S. Postal Service in the amount mentioned above), a postage free envelope is enclosed.

May we hear from you soon. Thank you in advance for your attention to this matter.

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

Enclosure

cc: Office of Workers' Compensation

*This paragraph is optional.

Exhibit 8-14A

Dog-Related Injuries;
First Request for Settlement of Claim

Certified No.

Employee:_____
OWCP No.:_____
Date of Injury:_____

Dear

On _____ your dog injured postal employee Carrier _____ without provocation, under the following circumstances:

Please be advised that _____ has assigned the full claim for personal injury to the Postal Service, pursuant to federal injury compensation law. The State of _____ provides a civil cause of action for those persons injured by dogs. This cause of action attaches liability to the owner or keeper of the dog, in this case you; the remedy provided is by way of compensatory damages for both out-of-pocket expenses and also for the pain and suffering sustained. It is this cause of action, for costs and for pain and suffering, which _____ has assigned to the Postal Service for pursuit.

We feel that the value of this claim is _____. The special damages (out-of-pocket expenses) are _____ with the remainder allocated to compensation to the employee for the emotional trauma, pain and suffering.

If you are insured, I suggest that you refer this matter to your insurance company. They possess the requisite expertise to deal with this, and I am sure we would reach a fair adjudication of the facts. If you are unsure of coverage, you should submit a claim, and they will advise whether coverage extends to the situation.

If you are not insured, or if for some reason you do not wish to refer the matter to your insurance company, I then look to you for satisfaction of the damages.

If you wish to settle this claim, please contact me at _____. I am enclosing a postage-paid return envelope if you wish to reply in writing.

Exhibit 8-14B

May I hear from you, your insurance company or your attorney by _____. I look forward to a prompt, fair settlement of the claim.

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

Enclosure

cc: _____
Ordinary Mail
OWCP, _____ District
bcc: Suspense (3 weeks) _____

Exhibit 8-14B

Installment Agreement

Employee: _____
Date of Injury: _____

Dear

Per our arrangement, enclosed is an installment agreement for your signature. Please sign both copies. Keep one copy for yourself and return the other to me in one of the enclosed envelopes along with your first payment.

No interest is charged. We are entering into this agreement as a convenience to you in settling out of court. My main concern is that your payments be made on time to avoid administrative costs. If this is done, I will not refer the matter to counsel.

Payments should be made to "U.S. Postal Service." Envelopes for submitting payments are enclosed. More are available on request.

If you have any questions, feel free to call me at _____.

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

Enclosures (2)

bcc: OWPC
Suspense (4 weeks) _____

Second Request for Settlement

Employee:_____
Date of Injury:_____

Dear

This is in regard to the injury of our employee, Carrier _____ on _____. Carrier _____ was injured, _____. We feel that your actions were the proximate cause of the accident, in that _____
_____.

We notified you of our status as assignee and our intent to pursue collection of the claim, without response from you. I cannot understand your failure to respond. Our claim is for a very reasonable amount but we are willing to negotiate to some extent and prefer to settle this matter amicably. However, we are unable to resolve this matter in the face of your silence. Again, I ask you to contact the Injury Compensation Office at _____, or use the enclosed postage-paid envelope for the courtesy of your reply.

If we do not resolve this matter soon, we will be forced to turn the case over to our legal counsel. May we hear from you by _____?

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

Enclosure

bcc: Suspense (3 weeks) _____

Exhibit 8-16

Third and Final Request for Settlement

Employee: _____
Date of Injury: _____

Dear

We have twice notified you of our claim arising from the injury of our employee _____, on _____, under circumstances which we feel indicate legal liability on your part. We have received no response as yet.

I cannot understand your failure to respond to our claim. By your silence you are denying us, and yourself, and opportunity to settle this claim out of court, without additional cost beyond the amount of the claim. I am unable to negotiate under this situation.

Please contact the Injury Compensation Office at _____ to discuss this matter, or reply using the enclosed postage-paid envelope.

If we do not hear from you by _____, we will refer the matter to our Regional Counsel for whatever action is deemed necessary.

Sincerely,

_____
Injury Compensation Specialist
Injury Compensation Office

Enclosure

bcc: Suspense (3 weeks) _____

U.S. POSTAL SERVICE EMPLOYEE'S THIRD PARTY RECOVERY STATEMENT			FILE NO.
CLAIMANT	DATE OF INJURY/DEATH	MSC	FINANCE NO.

WHEN A THIRD PARTY SETTLEMENT IS MADE WITHOUT AN ATTORNEY

1. Contact this office for the amount of disbursements.

2. If you were examined or treated at a Federal medical facility, contact that facility for the value of its service. If service was rendered by the U.S. Public Health Service, the Regional Counsel of the Department of Health and Human Services should be contacted.

3. Complete the recovery statement below and return it to this office. Enclose a check or money order for the amount appearing in item 5, below, made payable to "United States Postal Service."

The law provides that the United States must be reimbursed out of any third party recovery for any disbursements made by the Government. The term "disbursement" includes compensation, medical bills and transportation expenses. In addition the Postal Service is entitled to reimbursement for all continuation of pay (COP) payments made to you under section 8118 of the FECA. If no disbursements or COP were made, no refund is required. If there were disbursements requiring a refund, you are still entitled to a minimum amount of the recovery irrespective of any liens of the Government (see item 2c below).

1. Total recovery		$ _____
2. Less:		
a. Personal property damage		$ _____
b. Balance (item 1 less item 2a)		$ _____
c. Minimum guarantee (20 percent of item 2b—to be retained by you)		$ _____
d. Continuation of pay		$ _____
e. Medical expenses paid by you for which you have not received reimbursement from OWCP or an insurance carrier (attach itemization)		$ _____
f. Adjusted balance (item 2b less items c, d, and e)		$ _____
3. OWCP disbursements or item 2f, whichever is less	$ _____	$ _____
4. Plus continuation of pay (item 2d)	$ _____	
5. Total refund due U.S. Postal Service	$ _____	
6. Surplus (Line 2f less item 3)		$ _____

Following submission of this statement, you will be advised further concerning your compensation status.

DATE OF JUDGMENT OR RELEASE	SIGNATURE	DATE

The Federal Employee's Compensation Act, as amended (5 USC 8101, et seq.) is administered by the Office of Workers' Compensation Program of the U.S. Department of Labor. In accordance with this responsibility, the office collects and maintains personal information on claimants and their immediate families. The information will be used to determine eligibility for and the amount of benefits payable under the Act. The Postal Service uses the information in handling matters relating, directly or indirectly, to the subject matter of the claim in accordance with the provisions of 20 CFR 10. In addition, this information may be disclosed to an appropriate law enforcement agency for investigative or prosecutive purposes, to a congressional office at your request, to OMB for review of private relief legislation, to a labor organization as required by the NLRA, and where pertinent, in a legal proceeding to which the Postal Service is a party. Failure to provide the information requested may delay the adjudication process, or result in an unfavorable decision or a reduced level of benefits. However, disclosure of the social security number is voluntary and will not cause such delays; its only purposes are to enable the Postal Service to account for program costs and to verify the dollar amount of payments due the Department of Labor.

PS Form 2557 *(Copy to Employer)*

Subject: Recovery Disbursements-Third Party Settlement

To: Disbursing Officer
(Applicable Postal Data Center)

The attached check/money order in the amount of _____ _____ represents settlement of a third party claim for:

Name:

SSN:

OWCP Case No.:

These funds are forwarded for disposition (see attached Form 2556 or 2557 for amount of total recovery).

Disbursements are to be made as follows:

1. Credit COP account No. 52918 $ _____

2. Net amount due OWCP $ _____

Send check to U.S. Department of

Labor (applicable district office)

3. Net amount due employee $ _____

Send check to: [Employee's name]

c/o Injury Compensation Office

_____

Injury Compensation Supervisor/Specialist

Credit recovery MSC to Finance No. _____

_____

Attachment

Chapter 9
Miscellaneous

910 Program Reviews

911 Purpose

Reviews are essential to assure uniformity and consistency in the overall operation of the Injury Compensation Program. They identify strengths and weaknesses so that administration of the program can be improved.

912 Objectives of Program Reviews

To determine if:

a. Local management has implemented all controls and procedures required by the Injury Compensation Program.

b. Local management is reporting accurately injury statistics concerning activities designed to reduce manhours and costs.

c. Controversions are being handled properly.

d. Claims are being monitored and controlled properly.

e. The Rehabilitation Program is being effectively accomplished.

f. The Third Party Recovery Program is being aggressively pursued.

913 These objectives will be met by:

a. Reviewing case files of employees collecting benefits under FECA.

b. Evaluating control methods and procedures for monitoring cases.

c. Reviewing injury compensation reports for accuracy.

d. Interviewing control office personnel, line supervision, management, and claimants to assess overall program status.

e. Reviewing rehabilitation referral case files for compliance with USPS/DOL guidelines.

f. Reviewing third party liability cases to determine pursuit of potential claims in accordance with established procedures.

914 Program Responsibility

a. Headquarters - The Manager, Injury Compensation Branch, provides all policy and procedural guidelines to the region through the Assistant Postmaster General, Employee Relations Department.

b. Pegion - The Regional Injury Compensation Program Administrator (RICPA) provides guidance and information to the districts and management sectional centers through the Director, Employee and Labor Relations.

c. District - Provides information and coordination to the management sectional centers.

d. Management Sectional Centers/Bulk Mail Centers- The Injury Compensation Supervisor or Specialist (ICS) is responsible for the administration and control of the Injury Compensation Program in those offices authorized with injury compensation personnel. The ICS directs injury compensation personnel at the control office and designated control points.

915 Review Frequency

a. At the request of local management or by direction from a higher level of management, reviews will be conducted by an individual or team designated by the management official responsible for the administration of the ICP at that level.

b. The Injury Compensation Supervisor or Specialist will conduct a minimum of one formal review annually at all CAG E and above associate offices within the area of responsibility.

c. Bulk mail centers receiving MSC, E&LR support will be reviewed at least annually by the ICS of the supporting MSC.

916 Reporting

a. For regional or locally initiated reviews, the reviewing official or team will submit a formal report consolidating all significant findings to the RICPA.

A copy of the final report for MSC VI and above should be submitted to the Manager, Headquarters Injury Compensation Branch, to aid in monitoring major problem areas.

b. Major findings will be discussed with the installation head at the conclusion of the review.

c. Serious deficiencies will be brought to the attention of local management for immediate corrective action.

d. Follow-up reviews will be conducted as needed to ensure that corrective action has been taken.

e. Within 30 days after the review, local management must submit a report of action taken to correct deficiencies to the District Manager, with a copy sent to the RICPA.

f. Reports will be maintained for 5 years and then destroyed.

917 **Areas of Concern**

The following areas of responsibility will be reviewed:

a. Organization and administration within the office.

b. Training - extent of formal and informal training received concerning the Injury Compensation Program (ICP).

c. Staffing - adequacy of staffing to effectively implement the ICP.

d. Claims Management - effectiveness in controlling all aspects of claims:

1. Control of COP and LWOP/IOD hours.

2. Monitoring LDC codes.

3. Recordkeeping.

4. Timeliness in reporting injury to the control office.

5. Scheduling fitness-for-duty when appropriate, etc.

6. Referrals to the Inspection Service.

7. Preparing well-documented controversions.

e. Medical Management - coordination with available medical resources for proper control of claims.

1. Arrangement of fitness-for-duty exams.

2. Maintaining contact with the medical community.

3. Review of medical reports submitted in conjunction with claim.

4. Establishment of good working relationship with health and medical units.

f. Fraudulent Claims - identification, referral to Inspection Service, and proper monitoring of claims involving suspected fraud and abuse.

g. Limited Duty - employing "limited duty" as a means of controlling costs.

1. Identifying limited duty assignments.

2. Monitoring medical status for early return to regular duty.

3. Modifying job assignments to accommodate injured employees' limitations.

h. Rehabilitation Program -- Overall effectiveness of Rehabilitation Program as prescribed in the USPS/DOL Guidelines:

1. Initiating OWCP referrals.

2. Processing referrals in a prompt, efficient manner.

3. Conducting periodic interviews with rehabilitated employees as prescribed in guidelines.

4. Gaining top management's support of program.

i. Third Party Liability Program - Effectiveness of applying the third party procedures in Section 545.8 of the ELM.

j. Controversions - preparation of an objective and professional dispute of a questionable claim.

k. Timekeeping/Payroll - proper input and control of timekeeping elements relative to the ICP.

1. COP input

2. Adjustment

3. LDC 68, 69

4. Leave buy-back

5. Reconciliation of reports

6. Proper coding of Form 50s for rehabilitation employees (current or former)

918 Other Review Concerns

a. Goals established for current year.

b. Proper reporting of program activity statistics, i.e., Form 2572, *Injury Compensation Data Collection.*

c. Local management's attitude and support of program

d. Maintenance of essential reference materials for effective program management:

1. ECAB decisions.

2. Larson's Workmen's Compensation Law.

3. Federal Employees' Compensation Act (FECA).

4. Federal Personnel Manual (FPM) Chapter 810.

5. *Employee & Labor Relations Manual* (ELM) Chapter 540.

6. Chapter 1 of Title 20 CFR (Code of Federal Regulations).

920 Providing Counsel and Assistance

921 General Information

One of the primary functions of the Injury Compensation Office is to provide counsel and assistance to the injured employees as well as the supervisors. When an employee sustains a job-related injury/illness, explain to him the basic benefits provided under FECA and the following:

a. Entitlement to compensation for injuries/illnesses sustained in the performance of duty: 66 2/3% of basic salary and entitlements for employees without dependents; 75% for employees with dependents.

b. The importance of completion and timely submission of forms and related documentation, e.g., medical reports to the immediate supervisor.

c. Entitlement to COP for traumatic injuries up to a maximum of 45 days. If the injury extends beyond 45 days COP, the employee should be informed of the proper procedure to claim wage loss (CA-4 or CA-7). Explain the 3-day waiting period.

d. Explain the difference between use of sick/annual leave versus COP for item 16 of Form CA-1.

e. For totally disabled (permanent or temporary) employees, explain the difference between benefits under workers' compensation and Civil Service disability retirement, if eligible (See Exhibit 9-1).

f. The Department of Labor (DOL) adjudicates all claims, not the USPS. The USPS Injury Compensation Office acts as an intermediary in gathering information pertinent to the claim and submitting it to DOL. Decisions made by DOL can be appealed by the employee, but not the USPS.

g. If claim is approved by OWCP, explain procedure for leave buy-back, if requested by employee.

h. Penalties for submission of fraudulent claims as cited in 20 CFR 10.23.

1. Any person who makes a false statement to obtain Federal employees' compensation or who accepts compensation payments to which he is not entitled is subject to a fine of no more than $10,000 or imprisonment for no more than five years, or both.

2. Any person charged with the responsibility of making reports in connection with an injury who willfully fails, neglects, or refuses to do so; knowingly files a false report; induces, compels, or directs an injured employee to forego filing a claim; or willfully retains any notice, report, or paper required in connection with an injury, is subject to a fine of no more than $500 or imprisonment for no more than one year, or both.

i. Employee has the right to select his own physician, as long as the physician is located within 25 miles of the employee's place of employment or residence. However, if the employee wants to change the physician, after the initial selection has been made, justification must be provided and prior approval obtained from OWCP. COP/LWOP will not be authorized until such approval is received.

j. Death benefits should be explained to the survivors in fatality cases.

922 **Information for Supervisors:**

a. Basic benefits provided under FECA:

1. COP.

2. Compensation.

3. Medical expenses.

4. Rehabilitation expenses.

5. Death benefits for employee's survivors.

b. Timely submission of forms to IC control office/point.

c. Basis for controversion of COP.

d. Penalties involved for preventing or discouraging an employee from filing a claim.

e. Gathering and documenting data to substantiate suspected fraudulent claims.

f. Assistance in identifying limited duty assignments.

g. Assistance to supervisors in helping rehabilitation employees adjust to the work environment upon their return to work by providing follow-up counseling sessions, guidance and direction.

h. The supervisor's responsibilities:

1. Provide employee with a CA-1 and related forms when an injury is reported.

2. Immediately notify ICC office/point of the reported injury.

3. Assure employee is given proper authorization for medical treatment through control office/point when required.

4. Promptly submit CA-Forms to ICC office.

5. Advise employee of the rights and benefits under FECA. If employee elects sick/annual leave in lieu of COP, he must be advised that the leave cannot be bought back during the initial 45-day period.

930 Guidelines for OWCP Hearings

931 Right to Hearing

If the claimant is not satisfied with a decision by OWCP, he is entitled to a hearing by an OWCP representative before any review under 5 USC 8128(a) if:

a. The claim for compensation had been timely filed.

b. The request for the hearing is made within 30 days after the date the decision is issued.

932 Notice of Hearing

932.1 The OWCP hearing representative shall set the time and place of the hearing. When practicable, the hearing will be set at a time and place convenient to the employee. The hearing representative will mail the written notice to the employee at least 10 days prior to the hearing date with a file copy to the United States Postal Service (USPS).

932.2 A scheduled hearing may be postponed or cancelled at the option of the hearing representative or upon the written request of the employee if the request is received at least 2 days prior to the hearing date. ALWAYS RECONFIRM BY PHONE TO THE HEARING REPRESENTATIVE ONE (1) DAY PRIOR TO THE SCHEDULED HEARING DATE, THAT THE HEARING HAS NOT BEEN CANCELLED OR RESCHEDULED.

932.3 The USPS does not have the right to request a hearing but may send a representative (injury compensation supervisor, attorney or designee) to that hearing. (ATTACHED TO THE HEARING NOTICE WILL BE A QUESTIONNAIRE. COMPLETION OF THIS FORM WILL ADVISE THE OWCP OF THE USPS'S INTENTION OF SENDING A REPRESENTATIVE TO THE HEARING AND/OR REQUESTING A TRANSCRIPT OF THE HEARING.)

933 Subpoenas

The hearing representative may issue subpoenas for the attendance and testimony and for any other material required for the hearing.

934 Role and Responsibility of the Injury Compensation Supervisor/Specialist

934.1 After receiving notice of hearing, the injury compensation supervisor/specialist must review each case to determine whether attendance at the hearing is necessary. The USPS need not send a representative in every case but should send a representative to those hearings which involve:

a. A question of fact of injury.

b. A question of performance of duty.

c. A matter of special interest.

934.2 The USPS attends the hearing as an observer without the right to question or make any argument unless the employee or the hearing representative specifically requests information from the USPS. The USPS representative scheduled to attend the hearing should review and be thoroughly familiar with the employee's OWCP case file, any possible grievances, Equal Employment Opportunity (EEO) complaints and/or Merit System Protection Board (MSPB) actions in which the employee is involved.

935 Transcript of Hearing

935.1 A copy of the hearing transcript will be provided by OWCP's Branch of Hearing and Reviews when an official request is made by the USPS. USPS may obtain a copy of the transcript either by so requesting on the questionnaire attached to the hearing notice or by the postal representative's written request at the hearing.

935.2 If the USPS has requested a copy of the hearing transcript, 30 days are allowed following the release of the transcript to provide comments or include additional information (i.e., arbitration awards, inspection service reports, other relevant information) which should be furnished to the hearing representative to reinforce the Postal Service's viewpoint of the evidence submitted.

935.3 If necessary, the hearing representative may schedule another hearing when good cause is shown.

935.4 After USPS receives the transcript, the following actions should be taken:

a. Review thoroughly all the facts presented in the transcript.

b. Make written notations where a conflict exists and provide any additional documentation that would substantiate the Postal Service's position.

c. Prepare a letter of contention to the hearing representative citing the areas in dispute. All supplemental information pertinent to the case must be submitted within the 30-day time limit allowed for review and comments.

d. Seek other assistance when legal advice and guidance are deemed helpful in presenting the Postal Service's position relative to the issues raised at the hearings. Such cases may involve complex issues that warrant legal analysis or further interpretation of concepts relating to Postal Service policies. Legal advice and assistance may be helpful on questions of interpretation of the Federal Employees' Compensation Act and other statutes and in effectively marshalling any evidence that is to be submitted to the OWCP Hearing Representative.

Both Regional Counsel and the field office of the Law Department's Office of Labor Law are competent to provide this advice and assistance. If the claimant in the OWCP hearing is involved in other proceedings that are the subject of legal advice and assistance, such as appeals from disciplinary actions or grievances, the Office of Labor Law would normally be the appropriate source of legal counseling. In other cases, the Regional Counsel's office would generally be appropriate.

940 Directory of OWCP District Offices

National Office
Office of Workers' Compensation Programs
Employment Standards Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210-0999

Section of Regulations and Procedures
Diane B. Svenonius, Chief
(202) 523-8463
FTS 8 - 523-8463

Division of Vocational Rehabilitation
Charles Kilczewski, Chief
Sheila Hackett
Stella Lansing
Steve Rosen
James Thompson
(202) 523-6808
FTS 8 - 523-6808

Section of Technical Assistance
Richard Boylston, Chief
(202) 523-8453
FTS 8 523-8453

Office Address	Telephone Numbers Rehabilitation	Claims
Boston U. S. DOL, OWCP District Office No. 1 J.F.K. Federal Building, Room 1800 7th & Bolster Street Boston, MA 02130-1997	(617) 223-6749 or 6772 8-223-6749 or 6772	8-223-6757
New York U. S. DOL, OWCP District Office No. 2 1515 Broadway, Room 3326 New York, N.Y. 10036-5732	(212) 944-3361 or 3381 8-265-3361 or 3381	8-265-3387
Philadelphia U. S. DOL, OWCP District Office No. 3 3535 Market Street, Room 15100 Philadelphia, PA 19104-3364	(215) 596-1464 8-596-1464	8-596-1432
Norfolk U. S. DOL, OWCP District Office No. 5 Federal Building, Room 212 200 Granby Mall Norfolk, VA 23510-1806	(804) 441-3569 8-827-3569	8-827-3075
Jacksonville U. S. DOL, OWCP District Office No. 6 400 West Bay Street Box 35049 Jacksonville, FL 32202-4482	(904) 791-2821 8-946-2821	8-946-3426

Office Address	Telephone Numbers Rehabilitation	Claims
Houston U. S. DOL, OWCP District Office No. 8 2320 LaBranch Street, Room 2108 Houston, TX 77004-1031	(713) 226-5551 8-527-5551	8-526-6700
Cleveland U. S. DOL, OWCP District Office No. 9 1240 East 9th Street Cleveland, OH 44199-2054	(216) 522-3807 8-293-3807	8-293-2049
Chicago U. S. DOL, OWCP District Office No. 10 230 South Dearborn Street, 8th Floor Chicago, IL 60604-1541	(312) 556-5655 8-353-5655	8-886-5003
Kansas City U. S. DOL, OWCP District Office No. 11 911 Walnut Street, Room 1909 Kansas City, MO 64106-2085	(816) 374-2437 8-758-2437	8-758-2300
Denver U. S. DOL, OWCP District Office No. 12 Federal Building, Room 1425 Drawer 2558 1961 Stout Street Denver, CO 80294-0101	(303) 837-2658 8-327-2658	8-327-2612
San Francisco U. S. DOL, OWCP District Office No. 13 450 Golden Gate Avenue, Box 36066 San Francisco, CA 94102-3590	(415) 556-5336 or 3683 8-556-5336 or 3683	8-556-3095
Seattle U. S. DOL, OWCP District Office No. 14 Federal Office Building, Room 4010 909 First Avenue Seattle, WA 98174-1103	(206) 442-4229 8-399-4229	8-399-7923

Office Address	Telephone Numbers Rehabilitation	Claims
Honolulu U. S. DOL, OWCP District Office No. 15 300 Ala Moana Boulevard Room 5108, Box 50209 Honolulu, HI 96813-4980		Dial San Francisco FTS Operator 8-556-0220 Request Honolulu No. 808-546-8336
Dallas U. S. DOL, OWCP District Office No. 16 525 S. Griffin Square, Room 100 Dallas, TX 75202-5018	(214) 767-4701 8-729-4701	8-729-4708
Atlanta U. S. DOL, OWCP District Office No. 17 1371 Peachtree Street, NE Room 205 Atlanta, GA 30367-2702		8-257-7814
Washington, D.C. U. S. DOL, OWCP District Office No. 25 McLachlen Building, Room 405 666 - 11th Street, N.W. Washington, D.C. 20211-0001	(202) 724-0705 8-724-0705	8-724-0703
U.S. DOL, OWCP District Office No. 50 Branch of Special Claims 14th Street, NW P.O. Box 28608 Washington, DC 20005-0608		8-523-6490

Worker's Compensation vs. Disability Retirement

	WORKER'S COMPENSATION	VS	DISABILITY RETIREMENT
1.	MUST HAVE TOTAL OR PARTIAL DISABILITY OR PERMANENT IMPAIRMENT OF A SCHEDULED MEMBER OR FUNCTION OF THE BODY.	1.	NEED ONLY BE DISABLED FOR U.S. GOVERNMENT POSITION
2.	INJURY/ILLNESSES MUST BE JOB-RELATED	2.	ILLNESS DOES NOT HAVE TO BE JOB-RELATED
3.	COMPENSATION - 66 2/3% OR 75% OF PAY IF TOTALLY DISABLED OR OF LOSS OF EARNING CAPACITY IF PARTIALLY DISABLED	3.	DEPENDS ON THE LENGTH OF SERVICE AS A FEDERAL EMPLOYEE AND THE AGE OF EMPLOYEE. IN MOST CIRCUMTANCES THE MINIMUM IS 40% OF THE "HIGH 3" SALARY. THE MAXIMUM ONE MAY RECEIVE IS 80% WITH 41 YEARS 11 MONTHS SERVICE.
4.	NO MINIMUM SERVICE REQUIRED TO FILE	4.	NEEDS 5 YEARS SERVICE TO APPLY FOR DISABILITY RETIREMENT
5.	TOTAL TAX FREE	5.	DEPENDS ON EXTENT OF DISABILITY
6.	PERIODIC EXAMINATIONS ARE REQUIRED	6.	PERIODIC EXAMINATIONS MAY BE REQUIRED.

*U.S. GOVERNMENT PRINTING OFFICE: 1985-491-746:20034